



**James Rachels's Defense of Active Euthanasia:
A Critical & Normative Study**

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**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
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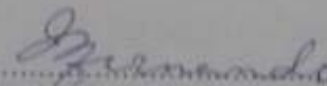
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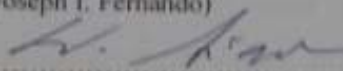
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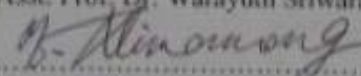


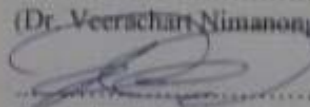
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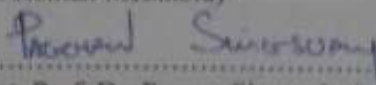

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ABSTRACT

The researcher believes that James Rachels's defense of active euthanasia deserves a critical and normative analysis because of its dehumanizing consequences. The researcher demonstrates that Rachels's position is conceptually, theoretically, practically, and normatively unjustifiable. The researcher supports his position by three steps.

Firstly, the researcher criticizes Rachels's conceptual framework which consists of three distinctions: biological and biographical life; killing and letting die; and ordinary and extraordinary medical treatment. The research shows that these distinctions do not provide a valid foundation or criteria for the permissibility of active euthanasia because of their conceptual, theoretical, and practical inadequacies. Rachels's first distinction is inadequate due to: (1) reductive fallacy (2) slippery slope and (3) irrelevance to main arguments. His second distinction is: (1) irrelevant, (2) extraneous and (3) degressive. His repudiation of the distinction of ordinary and extraordinary medical treatment is not valid.

Secondly, the researcher argues against Rachels's arguments against CDE. Rachels proposes four arguments which make the distinction between active and

passive euthanasia morally absurd. Therefore, Rachels argues that wherever passive euthanasia is allowed, active should be permitted too. The researcher shows that Rachels's arguments are theoretically flawed to support his position because most of his premises are either irrelevant or weak. Rachels's first claim is that often active euthanasia seems more humane than passive and therefore active euthanasia should not be only permitted but preferred too. The research shows two main responses to Rachels's claim which render his argument invalid. The first response is that Rachels argues against CDE on the basis not included in the AMA's statement. The research forwards the reasons which render Rachels's argument unimportant, irrelevant, and inadequate. Rachels's second claim is that the conventional view makes life-and-death decisions on irrelevant grounds therefore the conventional view, CDE, is not true. The research shows that the relevant grounds in CDE are the killing and termination of extraordinary medical care. Rachels's third claim is that there is no moral difference between doings and refraining, therefore wherever refraining is allowed doing should be permitted too; in other words, wherever passive euthanasia is allowed active should be allowed too. The research shows that Rachels's argument is invalid due to four reasons: (1) irrelevance to AMA's statement; (2) differences between the cases because of intentionality, causality, and agency; (3) straw man fallacy, and (4) weak analogy.

Thirdly, the researcher analyzes and argues against Rachels's direct arguments for active euthanasia which are from best interests and golden rule and autonomy. The researcher shows that the arguments are based on subjective moral claims and such claims are based on indefensible claims from liberty, rights and autonomy. The research demonstrates three reasons which render the best interest and golden rule

argument invalid. They are: (1) the argument is based on subjective moral judgment, failing the universalization test; (2) it may not be in my own best interests or in the best interests of others for me to die; and (3) the argument is based on indefensible autonomy. Rachels's third argument is from autonomy. The research demonstrates that argument from autonomy fails to claim the sufficient support to substantiate a pro-position for the approval of active euthanasia. The related reasons are: (1) invalidity of civil right's claim; (2) weak analogy (3) unwarranted influence of patient's autonomy, and (4) unattainable autonomy of the patients. Furthermore, Rachels proposes a 'modest proposal' for the legalization of active euthanasia. The research demonstrates that Rachels's proposal on legalizing active euthanasia is problematic and impractical.

Finally, the researcher shows that Rachels's categorization of active and passive euthanasia into killing and letting die is a false dichotomy. The researcher argues throughout the research that the third and the only choice is to stop prolongation of death by advanced medical technology and permitting termination of extraordinary medical care from dying person by following legitimate procedures.

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CHAPTER ONE

Introduction

1.1. Background, Significance, & Scope of the Study

This research is a critical and normative study of James Rachels's defense of active euthanasia. And by its academic and disciplinary nature, it falls within the philosophical discussions in medical ethics and legal theory. The research is critical and normative: Rachels's positions and arguments are conceptually, theoretically, and practically criticized; and his normative conclusions are challenged. In brief, the research is aimed at establishing the claim that James Rachels's defense of active euthanasia is conceptually, theoretically, practically, and normatively unjustifiable. To put Rachels's case briefly, he provides his own conceptual framework for the resolution of the issues related to euthanasia (Rachels, 1981 / 1994b, 1986b); he allegedly makes the distinction between active and passive euthanasia morally absurd (1975 / 1994a), and he finally argues in defense of active euthanasia (Rachels, 1981/ 1994b). In addition, Rachels provides a "modest proposal" for the legalization of active euthanasia (Rachels, 2003). Furthermore, Rachels argues that the opponents can not defend themselves rationally rather their position, according to him, is based on "a muddle of indefensible claims, backed by tradition but not by reason" (1981 / 1994b, p. 153). On the whole, Rachels's position on euthanasia is widely known as libertarian approach in contrast to traditional doctrine or conventional approach. Libertarian approach allows active euthanasia "mercy killing", whereas the traditional approach approves passive euthanasia in the sense of terminating extraordinary medical treatment and does not

permit active euthanasia.

The driving motivation for the topic stems from researcher's conviction that contemporary, intellectual discourse in support of euthanasia has potential consequences of leading to dehumanization, which ought to be rejected. The researcher thinks that permissibility of active euthanasia will lead to reducing a human being to a product, which at the point of losing its usefulness is disposed. As a result, human beings will end up being treated as disposable products rather than dignified persons. Euthanasia, by definition, is supposed to be for terminally ill persons; therefore children, adults, and elderly people are subjects to it, however, elderly people are the most vulnerable. The harshness of euthanasia supporters could be understood from what Colorado governor Richard D. Lamm said in an address, which was reported in *The New York Times*, March 29, 1984, to the Colorado Health Lawyers Association : "Elderly people who are terminally ill have a duty to die and get out of the way" (Kearl , 1989, p.125). Similarly, Richard Fenigsen, who conducted research on Dutch elderly people, argues that a society which promotes euthanasia sends a message to the vulnerable that their lives are not valued. Instead, such a society tells them, "we wouldn't mind getting rid of you" (Fenigsen, 1989, Social Implications, para. 1). It should be noted that active euthanasia is legal in Holland.

To return to the subject of euthanasia, it is of importance to mention that the issue of euthanasia is both new and old. It is new in the sense that most of the debate on the issue treats the matter as a consequence of the modern advanced medical technology. As a matter of fact, the rise of advanced medical technology, especially the artificially life-sustaining technology, has brought various moral issues to center stage

such as people can be kept alive against their wishes or in states of pain and in other forms of suffering. Moreover, it is also possible to keep people alive who are in a coma or a persistent vegetative state. In cases like these, the use of medical technologies raises questions about the moral appropriateness of sustaining life versus taking life or allowing someone to die. On the other hand, the issue of euthanasia is old in the sense that it involves issues of life and death on which thinkers and philosophers, from the ancient time, have held positions. The involvement of concepts such as killing and letting die, omission and commission, rights and duties, intrinsic value and inviolability of life, intention and foresight, and autonomy and paternalism are such issues which directly or indirectly touch the issue of euthanasia from many perspectives and link the issue with the philosophical tradition.

In the following parts of the chapter and in the rest of the research, the researcher provides the exposition of the issue of euthanasia; its historical origins and relevance with historical, philosophical debate on suicide; and its full development in our contemporary time. The crucial part of the research comprises of critical exposition of James Rachels's thought on the issue of euthanasia and its critical and normative study, which will eventually lead to evaluation of the issue in the third chapter and the justification of the thesis statement in the final chapter.

First and foremost, it is very important to have a clear definition of euthanasia. As a matter of fact, defining euthanasia and the relevant synonymous terms deserve a thorough tactful analysis because much of the confusion which besets the contemporary euthanasia debate can be traced to an unfortunate imprecision in definition. "Lack of clarity has hitherto helped to ensure that much of the debate has

been frustrating and sterile” (Otlowski, 1997, pp. 16-17). Therefore, defining euthanasia and the related terms is necessary in the outset of this research to ensure that conceptual framework of the subject remains clear, justice with reducing conclusions to proper definitions is realized, and the debate remains equivocation-free.

Euthanasia etymologically comes from two Greek words, *eu*, well, and *thanatos*, death, it means good or easy death (Baird & Rosenbaum, 1989, p. 9). Gradually the meaning of one word changed from the connotation of easy death to the actual medical deed necessary to make death easy. Finally it reached the connotation of mercy killing. Therefore, the common synonym for euthanasia in both lay and professional vocabularies has been mercy killing (Koop, 1989a, p. 69). Merriam-Webster's dictionary defines euthanasia as "an easy and painless death, or, an act or method of causing death painlessly so as to end suffering: advocated by some as a way to deal with victims of incurable disease" (2008). Similarly, the Euthanasia Society of America, founded in 1938, defines euthanasia as the "termination of human life by painless means for the purpose of ending severe physical suffering" (Hardon, 2004, Euthanasia, para.14). The American Medical Association's Council on Ethical and Judicial Affairs (1992) defines the term as follows: "Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy" (p. 2230).

The above definitions show that euthanasia is mercy killing in the sense of painlessly putting to death a terminally ill patient; however, there are other definitions which suggest that euthanasia also means refusing unwanted care or withdrawal of ongoing care (Adams, 1992, p. 2021). Therefore, there are two different uses of the

term “euthanasia.” The first is sometimes called the *narrow construal of euthanasia*. In this view euthanasia is equivalent to mercy killing. Thus, if a physician injects a patient with a drug with the intent to kill the patient, that would be an act of euthanasia; but if the physician withholds some extraordinary and excessively burdensome treatment from a patient and allows the patient to die in a natural way, that does not count as an example of euthanasia. The second view, sometimes called the *broad construal of euthanasia*, includes within the definition of euthanasia both mercy killing and cessation of extraordinary medical treatment i.e. *active euthanasia* and *passive euthanasia*. The broad construal is more widely used and is adopted in this research as well, because of its employment in Rachels’s works; although the researcher agrees only with the narrow construal of euthanasia.

Euthanasia is a general term and there are few widely used corresponding terms. These terms are definitions which decipher the meaning of different types of euthanasia. Among these terms are widely used active and passive euthanasia. Active euthanasia or euthanasia by action, also called mercy killing or positive euthanasia, is intentionally causing a person’s death by performing an action such as by giving a lethal injection. Passive euthanasia or euthanasia by omission, also called negative euthanasia, is the withholding or withdrawing the unnecessary and extraordinary medical treatment. Rachels (1983) widens the definition of active euthanasia; according to him it refers to the intentional and /or direct killing of an innocent human life either by that person, suicide, or by another, assisted suicide (p.19). Gifford (1993) describes the difference between the two types of euthanasia: “Passive euthanasia involves allowing a patient to die by removing her from artificial life support systems such as respirators and feeding

tubes or simply discontinuing medical treatments necessary to sustain life. Active euthanasia, by contrast, involves positive steps to end the life of a patient, typically by lethal injection” (p. 1546).

Active and passive euthanasia are the main categories, however, they are further classified depending on the relevant factors or circumstances such as *Voluntary*, *Involuntary*, and *Non-voluntary euthanasia*. The American Medical Association’s, AMA’s, Council on Ethical and Judicial Affairs (1992) makes three distinctions concerning consent and euthanasia as follows:

Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. Non-voluntary euthanasia is the provision of euthanasia to an incompetent person according to a surrogate’s decision. Involuntary euthanasia is euthanasia performed without a competent person’s consent. (p. 2230)

These distinctions while combined with the active / passive distinction form six different types of euthanasia: voluntary active, voluntary passive, non-voluntary active, non-voluntary passive, involuntary active and involuntary passive. Closely related to euthanasia are terms such as *assisted suicide* and *physician assisted suicide*. Assisted suicide is when someone provides an individual with the information, guidance, and means to take his or her own life with the intention that they will be used for this purpose. Likewise, when it is a doctor who helps another person to kill himself or herself it is called physician assisted suicide. However, there is a sharp difference between euthanasia and physician assisted suicide. The AMA’s Council on Ethical and

Judicial Affairs (1992) states as follows:

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life ending action (e.g., administering a lethal injection). Assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and /or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). (p. 2231)

The researcher holds that euthanasia is only the narrow construal of euthanasia; that is active euthanasia alone. The researcher's contention is that since euthanasia enfolds the meaning of intentional, mercy killing in what has come to be known as passive euthanasia intentional killing is not part of the withholding or withdrawing the unnecessary and extraordinary medical treatment. The confusion between suicide, assisted suicide, physician assisted suicide, and euthanasia also deserves some analysis. This confusion of terms is very widespread in the well circulated literature on euthanasia; most importantly, Rachels, as noted earlier, confuses these terms too, his definition of active euthanasia includes mercy killing, suicide, assisted suicide and physician assisted suicide (Rachels, 1983, p.19).

The researcher holds that passive euthanasia, suicide, assisted suicide, and physician assisted suicide are not euthanasia; only active euthanasia "mercy killing" is euthanasia. The researcher's definitional understanding is in consistency with AMA's definitions. Therefore, the researcher's definition of euthanasia is: intentionally causing

a terminally ill person's death for the reasons of mercy . The analysis of the definition is as follows:

Person X commits euthanasia on Person Y if

- i. X takes the life of Y
- ii. Y is suffering from a disease or injury from which Y is not expected to recover
- iii. the action of X's taking Y's life is intentional

The definition includes: voluntary, non-voluntary, and involuntary active euthanasia. The definition excludes: suicide, assisted suicide, physician-assisted suicide and passive euthanasia.

The definition is based on the facts that: (1) the death is caused by an agent (human) instead of the subject (the patient), (2) the causing of death is intentional (3) the death is caused either by the request of the subject or the state of the subject to make it different from a pure homicide (4) the death is caused by commission or action and (5) the subject is terminally ill. Therefore, euthanasia as defined above will include only active euthanasia.

The reasons behind not considering passive euthanasia as euthanasia is due to: (1) the death is natural, and not artificial (2) the death is not caused by action of any agent. The suicide, assisted suicide, and physician assisted suicide are excluded due to: (1) the death is not caused by an agent other than the subject. The very integral factor of the notion of euthanasia is being killed by some agent (person) instead of the subject.

After definitional analysis of euthanasia, a brief historical sketch of euthanasia and its development is noteworthy to put the intellectual threads on the issue together. The problem of euthanasia has a long history of philosophical discussion. However, most of the discussion revolves around the issue of suicide. The discussion of suicide itself could be related to problem of euthanasia since both of them aim at termination of life. The researcher thinks that suicide is a general concept whereas euthanasia is a special case. Euthanasia is about a terminally ill person whereas suicide enfolds various possibilities and motives for opting termination of life. Therefore, the relation between suicide and euthanasia is a relation between universal and particular. However, lines of distinction could be drawn between suicide and euthanasia. “Euthanasia—it might be claimed—is an alleged solution for the ills of dying, whereas suicide is an alleged cure for the ills of living” (Donnelly, John, 1998, p.10). On the other hand, wishing death and planning the steps toward ending a life is shared by both euthanasia and suicide. The quality of life and its intrinsic value remain central in both euthanasia and suicide. Both these issues share many common threads which bring suicide and euthanasia on parallels, if not completely, nevertheless, partially. Therefore, in the historical sketch of the problem the distinction between suicide and euthanasia is intentionally considered irrelevant because suicide is general and in principle it includes euthanasia. And “Indeed, to justify either one, suicide or mercy killing, is to justify the other” (Fletcher 1987 / 1989, p. 91).

The intellectual and academic debate of euthanasia draws on history of western philosophy ranging from the ancient to contemporary time. The expounding philosophers on the issue could be categorized into three groups: opponents,

proponents, and moderates. Opponents such as Hippocrates, Aquinas, Kant, and Hegel claim that suicide is always morally wrong; proponents include Epicurus, Seneca, Montaigne, Montesquieu, Holbach, Diderot, Rousseau, Voltaire, Schopenhauer, and Nietzsche; and moderates such as Plato and Hume hold that suicide is both moral and immoral depending on the motivating factors and the contexts. Therefore, the following account will be a precise literature review of the case with some elaborations wherever necessary.

In ancient Greece, euthanasia was not practiced, and suicide was generally disfavored. In fact, Athenian law treated suicide as a crime, punishing the guilty by amputating the corpse's right hand and denying traditional burial rituals (Mair, 2007, pp. 26-30). However, Alvarez (1971) suggests that although suicide was taboo, the Greeks tolerated suicide in some circumstances (p.58). Meanwhile, Hippocrates (460-370 BCE), the ancient Greek physician, strongly opposed euthanasia, assisted suicide, and physician assisted suicide. Wording of his famous oath attests his position: "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death" (Hippocrates, 2005). Accordingly, Hippocrates' oath has since then normatively defined the medical profession as life saving. Some Greek philosophers, such as, Plato did add three exceptions to the immorality of suicide. According to him, suicide might be permissible when compelled by (1) judicial order, (2) excruciating misfortune, or (3) moral disgrace (Plato, 1980, p. 268). However, Plato's exceptions do not apply to permissibility of active euthanasia. Nevertheless, Plato seems to be in favor of passive euthanasia; in *The Republic*, Plato argued that patients should be permitted to refuse intrusive medical treatments that may lengthen their lives, while

making them very unpleasant and useless to the state (Plato, 1991, p. 84-89). On the contrary, Aristotle believed that suicide was unjust under all circumstances, because it deprived the community of a citizen (Aristotle, 1999, p. 84). Regardless of Aristotle, the Stoics focused more strongly on the welfare of the individual than on the community. Roman Stoics such as Annaeus Seneca (4 B.C.E.-C.E. 65) argued that the individual should have broad discretion to end his or her own life. Seneca emphasizes considerations of quality of life over mere existence and recommends dying well as an escape from the ills of living (Seneca. (1917/ 1998, pp. 35-39).

In medieval times, Christian, Jewish, and Muslim philosophers opposed active euthanasia, although the Christian Church has always accepted passive euthanasia and condemned active euthanasia. The most influential and scholastic defense of Catholic position comes in the thirteenth century by Thomas Aquinas (1225-1274). Aquinas gave three highly influential arguments for the immorality of suicide: (1) it contravenes one's duty to oneself and the natural inclination of self-perpetuation; (2) it injures other people and the community of which the individual is a part; and (3) it violates God's authority over life, which is God's gift (Aquinas, 1947, 11, 11, Q.64, Art.5.). This position shaped attitudes about suicide that prevailed from the Middle Ages through the Renaissance and Reformation. By the sixteenth century, philosophers began to challenge the generally accepted religious condemnation of suicide. Michel de Montaigne, a sixteenth-century philosopher, argued that suicide was not a question of Christian belief but a matter of personal choice (Fengren, 1989, pp. 159-61).

During the Renaissance, Thomas More (1478-1535) defended euthanasia; according to him when a patient has a torturous and incurable illness, the patient has the

option to die, either through starvation or opium (More, 1999, p. 22.). In the eighteenth century, David Hume (1711-1776) made the first unapologetic defense of the moral permissibility of suicide on grounds of individual autonomy and social benefit. Hume's defense is utilitarian and he disagrees with the arguments of Aquinas. However, Hume did not advocate that all suicides are justified, but argued that when life is most plagued by suffering, suicide is most acceptable (Hume, 2004, p.2-8). Other philosophers of the Age of Reason, such as John Locke and Immanuel Kant, opposed suicide. Locke argued that life, like liberty, represents an inalienable right, which cannot be taken from, or given away by, an individual (Fengren, 1989, pp. 173-75). For Kant (1724-1804), suicide was a paradigmatic example of an action that violates moral responsibility. Kant believed that the proper end of rational beings requires self-preservation, and that suicide would therefore be inconsistent with the fundamental value of human life (Kant, 1785).

The nineteenth and early twentieth centuries brought several developments that, while not explicitly philosophical, have shaped philosophical thought about suicide. Michael Cholbi (2004) points out these developments: (1) the emergence of a Romantic idealized 'script' for suicide in novels by Rousseau, Goethe, and Flaubert, according to which suicide was the inevitable response of a misunderstood and anguished soul jilted by love or shunned by society (Lieberman 2003.); (2) the recognition of psychiatry as an autonomous discipline capable of diagnosing and treating the ailments responsible for suicide; and (3) the work of sociologists such as Durkheim and Laplace, who viewed suicide as a social ill reflecting widespread alienation, anomie, and other attitudinal byproducts of modernity. Moreover, suicide

was of central concern for the twentieth century existentialists, who saw the choice to take one's life as impressed upon us by our experience of the absurdity or meaninglessness of the world and of human endeavor (Section 2.3, para. 9-10).

The late twentieth century represents two aspects of the issue of suicide. The debate becomes divided into two separate discourses: suicide and euthanasia. Both these subjects became separate along with their subject matter and arguments; although there is unavoidable overlap between them. The nature of euthanasia becomes special because it touches medical profession and debate over rights and duties. Thus euthanasia widely becomes interdisciplinary and subject of legal analysis in various countries.

Tracking the developments regarding euthanasia in twentieth century, the societies which advance the cause of positive euthanasia were founded in 1935 in England and in 1938 in the United States. Since 1937 assisted suicide has been legal in Switzerland as long as the person who assists has no personal motive or gain. The Second World War changed the atmosphere of discussion on euthanasia. In 1939, the Nazis practiced euthanasia in various specialized medicine departments; the victims were gassed or poisoned. After the Second World War, the debate became silent for a long period until the 1970s. In the 1970s and early 1980s, the discussion on euthanasia became a more extensive academic and public debate. This is the same period when James Rachels wrote his major works. The Northern Territory of Australia was the first state to pass laws allowing a physician to end the life of a terminally ill patient, but just 6 months after the first death under the passed act, the act was overturned by the Australian Federal Senate. On 27 October 1997, the state of Oregon legalized

physician-assisted suicide. In 1993, the Netherlands decriminalized, under a set of restricted conditions, voluntary active euthanasia, essentially, physician-assisted suicide, for the terminally ill, and in 2002 the country legalized physician-assisted suicide if voluntarily requested by seriously ill patients who face ongoing suffering. Belgium has also legalized euthanasia since 2002 for certain patients who have requested it. Besides these developments, the discourse on euthanasia is continuously in progress attracting attention from experts of various disciplines and likewise the issue has been subjected to public opinion polls time to time.

Apart from every sort of disciplinary perspective on the issue of euthanasia, the issue in its essential relation is practically connected with medicine. The issue of euthanasia has brought the medical profession in question. The traditional and common sense understanding of the profession is life saving. However, the defenders of active euthanasia suggest the redefining the profession not only as life saving, but also life taking. From that point on, the issue touched the legality of practicing euthanasia on the grounds of autonomy, rights, and duties. Autonomy, not only of patients, but of doctors too. And duty, not only of doctors to kill a patient, but of patients too in a psychologically shaped euthanasian culture. And most of all, the status of rights of a patient to claim such a right. Due to the crucial touch of euthanasia to medical profession, on December 4, 1973, the House of Delegates of the American Medical Association (AMA) asserted its position on the issue of euthanasia as follows:

The intentional termination of the life of one human being by another--mercy killing--is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and /or his immediate family. (as cited in Rachels, 1975 / 1994a, pp. 112-113)

The above statement generated a prompt debate on the issue both in the field of ethics and legal theory. The AMA's position on the issue came to be named as conventional doctrine on euthanasia (CDE) or traditional view. It is important to mention that AMA's position, although adopted in the United States, its message resonates globally in the forums and associations that are concerned with the issue. In accordance with the AMA's position, the World Medical Association's Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, in October 1987, states:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness. (World Medical Association, 2002, Section, 1)

James Rachels (1941-2003), the distinguished American moral philosopher, criticized the AMA's statement just after its publication; he is the most outspoken rebutter of the position. His approach to euthanasia came to be known as libertarian

view. Rachels was born in Columbus; he received his Ph.D. in 1967 from the University of North Carolina. He taught at the University of Richmond, New York University, the University of Miami, Duke University, and the University of Alabama at Birmingham. 1971 saw the publication of his groundbreaking anthology *Moral Problems*. In 1975, Rachels wrote "*Active and Passive Euthanasia*," originally appearing in the *New England Journal of Medicine*, this essay has been reprinted 300 times. *The End of Life* (1986) broadened and deepened his ideas on euthanasia. His *Created from Animals* (1990) argued that a Darwinian world-view has widespread philosophical implications, including drastic implications for our treatment of nonhuman animals. *Can Ethics Provide Answers?* (1997) was Rachels's first collection of papers; *The Legacy of Socrates* (2007) was his second. Rachels's textbook, *The Elements of Moral Philosophy*, is currently the best-selling book in philosophy. Shortly before being diagnosed with cancer, Rachels finished *Problems from Philosophy*, an introduction to his subject, published posthumously. Over his career, Rachels wrote 5 books and 86 essays, edited 7 books and gave about 275 professional lectures (Official Website of James Rachels, n.d. Brief Biography, para.1-2).

In criticizing the AMA's position on euthanasia, Rachels's first attempt was to show that there is morally no difference between active and passive euthanasia, and where passive euthanasia is appropriate, active should be allowed too; he elaborated on the idea in his article "*Active and Passive Euthanasia*" (1975/ 1994a). He challenged the conventional doctrine of euthanasia (CDE) for several reasons: active euthanasia is in many cases more humane than passive euthanasia; the conventional doctrine leads to decisions concerning life and death on irrelevant grounds; the doctrine rests on a

distinction between killing and letting die that itself has no moral importance; and the most common arguments in favor of the doctrine are invalid. Secondly, Rachels in “More Impertinent Distinctions and a Defense of Active Euthanasia” (1981/ 1994b) explicitly supported active euthanasia. Rachels stated two main arguments: the first is the argument from mercy; the second is the argument from the best interests and the golden rule. He added one more argument for the legalization of active euthanasia based on the right to liberty and autonomy. (Rachels, 1983, p.19). Thirdly, Rachels is a moral, utilitarian philosopher; while elaborating his thought on euthanasia, he refers directly and indirectly to his conceptual framework which permeates all of his arguments. Rachels’s conceptual framework deals with distinctions such as *biological* and *biographical life*, *killing* and *letting die*; and *ordinary* and *extraordinary medical treatment*. In addition to that, in his rejoinder article “An Argument against Legalizing Active Euthanasia: The Slippery Slope” (2003), Rachels provided the detailed framework on the legislation for active euthanasia. The chapter two of this research deals with the abovementioned ideas of Rachels in a detailed form. The ideas are grouped in three categories respectively: conceptual framework, arguments for abolition of the distinction between active and passive euthanasia, and arguments for active euthanasia including the proposal on legislation for active euthanasia respectively.

The criticism of Rachels’s thought on euthanasia is detailed in chapter three. The criticism is conceptual and normative. The arguments developed by Rachels are addressed. The chapter analyzes firstly, the conceptual framework of Rachels and demonstrate its inadequacy on conceptual and practical basis; secondly, it demonstrates

the theoretical problems in Rachels's arguments which attempt to prove the distinction between active and passive euthanasia is morally absurd, therefore, the criticism leads to invalidity of the active euthanasia. And thirdly, it criticizes Rachels's arguments for active euthanasia by showing their weaknesses which affect their soundness. In addition, the researcher also shows the problems in Rachels's proposal on the legalization of active euthanasia which renders his proposal problematic and impractical. And, lastly, the researcher debates that there is only one type of euthanasia which is active euthanasia and which ought to be rejected, due to its unjustifiability. Finally, the researcher shows that Rachels's active and passive dichotomy is a false dichotomy.

The chapter four summarizes the research and concludes the findings by establishing the thesis statement and furthermore mentions also the further research and recommendations.

1.2. Thesis Statement

James Rachels's defense of active euthanasia is conceptually, theoretically, practically, and normatively unjustifiable.

1.3. Objectives

1.3.1. To provide a detailed exposition of the issue of euthanasia. The exposition includes the explanation of the terms and definitions, the historical background of the issue, and the current debate on the issue.

1.3.2. To provide the descriptive exposition of James Rachels's view on euthanasia

1.3.3. To provide a critical study of Rachels's view on euthanasia.

1.3.4. To provide the justification of the thesis statement.

1. 4. Limitation and Methodology of the Research

The limitations on the research are as follows:

1.4.1. This is a focused research on James Rachels's defense for active euthanasia. The research is therefore basically confined to his works on the issue.

1.4.2. This research will address only those arguments which are explicitly detailed in the works of Rachels. It includes the arguments which he develops, supports, or refutes.

1.4.3. The approach of argumentation is secular. Therefore, religious arguments are not included. However, rational arguments, though, labeled or proclaimed as religious will be included.

1.4.4. The nature of the research methodology is on parallels with Rachels's methodology which is conceptual, practical, theoretical and normative.

1.4.5. The methodology employed will combine conceptual analysis, criticism, and argumentation. Firstly, the analysis and presentation of Rachels's thought will be undertaken. His arguments and position will be made clear. And secondly criticism of his arguments and position will be undertaken by two ways: by finding problems within his thought and by arguing against his position. The debate of the issue is not confined to any ethical criteria or to any ethical theory among normative ethical theories, rather the issue is tackled by independent arguments.

1.4.6. This research is not meant to reach on conclusions on the issue of euthanasia, but to attempt to reach on conclusions on Rachels's defense of active euthanasia.

CHAPTER TWO

Exposition of Rachels's Thought on Euthanasia

2.1. Introduction

James Rachels's thought on euthanasia begins from his counter and refuting responses to the American Medical Association's (AMA's) statement, which stated its position on euthanasia by endorsing, according to Rachels, the traditional doctrine of euthanasia (TDE) or conventional doctrine of euthanasia (CDE). Rachels's first attempt was to show that there is morally no difference between active and passive euthanasia. In his article "Active and Passive Euthanasia" (1975/ 1994a), which appeared in The New England Journal of Medicine, he did not argue in support of active euthanasia explicitly. His main attempt, in the article, was to show that there is no moral difference between active and passive euthanasia, and where passive euthanasia is appropriate, active should be allowed too. However, in his rejoinder essay, "More Impertinent Distinctions and a Defense of Active Euthanasia" (1981/ 1994b), he explicitly supported active euthanasia in an argumentative manner. Both the abovementioned articles, and the reproduction of the same thought in his numerous articles (1977, 1979a, 1979b, 1980, 1981a, 1981b, 1984, 1993, 2001, & 2002), contained the most of the conceptual framework which Rachels uses in his works. Finally, in "The End of Life: Euthanasia and Morality" (1986b), Rachels gave a systematic shape to his ideas and elaborated comprehensively on all aspects of the related issues. Rachels's abovementioned works suggested the moral and practical permissibility of voluntary active euthanasia to medical doctors and judicial courts. In addition to that, in his

rejoinder article “An Argument against Legalizing Active Euthanasia: The Slippery Slope” (2003), Rachels provided the detailed framework for the legalization of active euthanasia.

The arrangement and ordering of Rachels's ideas in this chapter is different from the chronological order of his writings; due to need of understanding his thought in a logical order for the convenience of comprehension and criticism. Therefore, his conceptual framework is sketched firstly; his arguments showing the morally absurd distinction between active and passive euthanasia are elaborated secondly; thirdly his arguments in favor of active euthanasia are explained with details; and finally his proposal on legalizing active euthanasia is stated precisely. Meanwhile, his responses to rejoinders are mentioned during the course of explicating his arguments. The best part of his instant responses to rejoinders, during his lifetime, is that they have served a stimulus to Rachels to speak out more clearly on many related issues. For example, in his article “More Impertinent Distinctions and a Defense of Active Euthanasia” (1981/1994b) which is partially a response to Thomas D. Sullivan's article, “Active and passive euthanasia: An impertinent distinction?” (1977/1994a), Rachels, further explains notions such as intentionality; ordinary and extraordinary means of treatment; and arguments which support active euthanasia.

Therefore, the chapter is based on three areas: conceptual framework, arguments for absolution of the distinction between active and passive euthanasia, and arguments for active euthanasia including the proposal on legalization of active euthanasia respectively.

2.2. Rachels's Euthanasian Conceptual Framework

Rachels is a moral, utilitarian philosopher; while elaborating his thought on euthanasia, he refers directly and indirectly to his conceptual framework which, in fact, permeates all of his arguments. In brief, Rachels's conceptual framework comprises of *distinctions such as biological and biographical life; killing and letting die; and ordinary and extraordinary medical treatment*. The most of these distinctions make sense both theoretically and practically only if the passive euthanasia is accepted as given and permissible. On the whole, Rachels shows that biographical life is morally relevant whereas mere biological life is not so; there is morally no difference between killing and letting die ; and the ordinary and extraordinary distinction is senseless. The following part of the chapter precisely explicates this conceptual framework.

2.2.1. Biological Life and Biographical Life

Rachels makes a distinction between *biological* and *biographical* life; his support for active euthanasia is largely based on this distinction. The biological life is being a living being. Whereas, according to Rachels, biographical life is “the sum of one's aspirations, decisions, activities, projects, and human relationships” (Rachels, 1986b, p. 526, 33, 35, 38, 47, 49-59, 65, 76, 85). Rachels claims that the mere fact that something has *biological* life, whether human or nonhuman is relatively unimportant from an ethical point of view. What is important, according to Rachels, is that someone has *biographical* life. The facts of a person's biographical life are those of that person's history and character. They are the interests that are important and worthwhile from the point of view of the person himself or herself. The value of one's biographical life is the

value it has for that person, and something has value if its loss would harm that person (Rachels, 1986b, p. 38). The distinction is such a drastic that it, in principle, does not support only voluntary active euthanasia, but also non-voluntary and involuntary, though Rachels would finally agree on voluntary active euthanasia only.

The significant implication of the above view entails that certain persons without a prospect for biographical life, and certain terminally ill patients, are of little intrinsic concern, morally speaking. Though they may be alive in the biological sense, they are not alive in the biographical sense. And the latter is what is relevant to morality. Therefore, the distinction gives a considerable and decisive weight to Rachels's position, that such persons, who are biologically alive but biographically without any prospect, are subjects of active euthanasia.

2.2.2. Killing and Letting Die

Rachels argues that there is morally no distinction between killing someone and letting someone die. Furthermore, he argues that intentions are not relevant to moral judgments. The implication of the distinction is related to the active/passive dichotomy. According to Rachels, active euthanasia involves actually killing the sick individual, whereas passive euthanasia involves simply letting the person die. Rachels, by applying the above concept, attempts to show that the active / passive dichotomy is a distinction without difference. To demonstrate the distinction, he forwards a main argument: the bare difference argument or equivalence thesis. The implication, which follows from the argument, is that the cases where passive euthanasia is permissible are also the cases where active euthanasia should be permissible too.

Rachels, while explaining the above distinction, sets up two cases that are supposed to be exactly alike except that one involves killing and the other involves letting die. The cases are hypothetical, which involve two characters: Smith and Jones. Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident. As a result, Smith gets his inheritance without getting caught. On the other hand, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip, hit his head, and fall face-down in the water. Jones is delighted; he stands by; ready to push the child's head back under if necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, accidentally, as Jones watches and does nothing. As a result, Jones gets his inheritance without facing any blame (Rachels, 1975/ 1994a, pp. 115-116; 1986b, p. 112).

According to Rachels, neither man behaved better even though Smith killed the child and Jones merely let the child die. Both acted from the same motive, personal gain, and the results were identical, death. Thus according to Rachels, the only difference between the two cases is killing versus letting die, and since the cases are morally equivalent, this distinction is morally irrelevant. Therefore, the above hypothetical case, according to Rachels, makes the distinction between active and passive euthanasia absurd. They are morally the same; therefore, where "letting die" is permissible, "killing" should be allowed too. The other meaning could be if killing is not allowed, letting die should be prohibited too; but that is not what Rachels aims at, he would

rather, support killing in the case.

The bare difference argument, as illustrated above, which shows that there is no difference between killing and letting die, faced a response from Thomas D. Sullivan. In summary, Thomas D. Sullivan's point is that the difference is due to difference in intentions (1977/1994a). He claims that in active euthanasia the doctor intends to kill, whereas in passive euthanasia the intent is not involved. Rachels attempts to refute the claim, and while discrediting Sullivan's position, Rachels concludes that rightness or wrongness of an act is determined by the reasons for it or against it, and intention as such has morally no importance. Rachels further adds that if a person is trying to decide whether treatment should be continued; he should think about the reasons for and against it. Rachels responds that on the one hand, if treatment is ceased the terminally ill person will die very soon, and on the other hand, the person will die eventually anyway, even if treatment is continued. He adds that, moreover, if the persons' life is prolonged, its suffering will be prolonged as well, and the medical resources used will be unavailable to others who would have a better chance of a satisfactory cure.

In light of all this, Rachels concludes, you may well decide against continued treatment. Rachels draws attention to the fact that there is no mention here of anybody's intentions. Rachels emphasizes that "the intention you would have, if you decided to cease treatment, is not one of the things you need to consider. It is not among the reasons either for or against the action. That is why it is irrelevant to determining whether the action is right" (Rachels, 1981/ 1994b, p.143). Rachels further states that a person's intention is relevant to an assessment of his character; intentions are relevant for thinking a person a good or a bad person. But, according to Rachels, the intention is

not relevant to determining whether the act itself is morally right; according to Rachels, the rightness of the act must be decided on the basis of the objective reasons for or against it. He, therefore, concludes that the traditional view is mistaken on this point (Rachels, 1981/ 1994b, p.143).

2.2.3. Ordinary and Extraordinary Means of Treatment

Rachels, while attempting to find the flaws in the AMA's statement, criticizes the statement which states that life sustaining treatment may sometimes be stopped if the means of treatment are "extraordinary"; with the implication that "ordinary" means of treatment may not be withheld (Rachels, 1981/ 1994b, p.143). The distinction between ordinary and extraordinary treatments is crucial and Thomas D. Sullivan reemphasizes and reaffirms its importance in a rejoinder to Rachels (Sullivan, 1994b).

Responding to the above distinction as held in the traditional view, Rachels states that, however, "upon reflection it is clear that it is sometimes permissible to omit even very ordinary sorts of treatments". (Rachels, 1981/ 1994b, p.143). Rachels debates the definitions of ordinary and extraordinary means of treatment which are briefly mentioned in the AMA's statement and are well extended by Thomas D. Sullivan. Rachels, therefore, makes his objections to the Sullivan's understanding of the distinction as a representing commentary of the AMA's statement.

Thomas D. Sullivan in fact bases his understanding of the distinction on the following definitions of Paul Ramsey:

Ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and

which can be obtained and used without excessive expense, pain, and other inconveniences. Extraordinary means of preserving life are all those medicines, treatments, and operations which cannot be obtained without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. (as cited in Sullivan, 1994a, p. 135)

Rachels criticizes the above definitions and claims that they are useless. He states two problems regarding the distinction which, according to his understanding, render the distinction senseless. Rachels takes the definitional analysis of the distinction.

Rachels, firstly criticizes the way the word "excessive" functions in these definitions. He states that it is said that a treatment is extraordinary if it cannot be obtained without excessive expense or pain. He, therefore, poses the question: when is an expense "excessive"? He adds, "is a cost of \$10,000 excessive? If it would save the life of a young woman and restore her to perfect health, \$10,000 does not seem excessive. But if it would only prolong the life of Ramsey's cancer-stricken diabetic a short while, perhaps \$10,000 is excessive". Rachels concludes that the point is not merely that what is excessive because it changes from case to case; what is excessive depends on whether it would be a good thing for the life in question to be prolonged (Rachels, 1981/ 1994b, p. 144).

Secondly, Rachels turns to the use of the word "benefit" in the definitions. He states that it is said that ordinary treatments offer a reasonable hope of benefit for the patient; and that treatments are extraordinary if they will not benefit the patient (Rachels, 1981/ 1994b, p. 145). Rachels responds to the above by saying that how do

we tell if a treatment will benefit the patient? He reminds that we are talking about life prolonging treatments; the "benefit," if any, is the continuation of life. Whether continued life is a benefit depends on the details of the particular case. For a person with a painful terminal illness, a temporarily continued life may not be a benefit. For a person in irreversible coma, such as Karen Quinlan, continued biological existence is almost certainly not a benefit. On the other hand, for a person who can be cured and resume a normal life, life-sustaining treatment definitely is a benefit. Therefore he concludes that in order to decide whether life-sustaining treatment is a benefit we must first decide whether it would be a good thing for the life in question to be prolonged (Rachels, 1981/ 1994b, p. 145).

After making above two objections, Rachels concludes that these definitions do not mark out a distinction that can be used to help us decide when treatment may be omitted. Rachels states that we cannot, by using the definitions, identify which treatments are extraordinary, and then use that information to determine whether the treatment may be omitted. For the definitions, Rachels points out, require that we must already have decided the moral questions of life and death before we can answer the question of which treatments are extraordinary (Rachels, 1981/ 1994b, p. 145) Rachels concludes his debate as follows:

If we apply the distinction in a straightforward, commonsense way, the traditional doctrine is false, for it is clear that it is sometimes permissible to omit ordinary treatments. On the other hand, if we define the terms as suggested by Ramsey and Sullivan, the distinction is useless in practical decision making. In either case, the distinction provides no help in

formulating an acceptable ethic of letting die. (Rachels, 1981/ 1994b, p. 145)

The above mentioned conceptual framework which sets distinctions is present almost in every argument of Rachels. The following part of the chapter presents Rachels arguments against traditional doctrine on euthanasia (TDE), which makes the distinction between active and passive euthanasia; Rachels argues that the distinction is morally absurd and , therefore, where passive euthanasia is allowed, active euthanasia should be permitted as well.

2.3. Rachels's Arguments against Traditional Doctrine on Euthanasia (TDE)

Rachels argues against the traditional doctrine on euthanasia, which is also called as conventional doctrine on euthanasia (CDE) or standard view; which makes a distinction between active and passive euthanasia. This view is, according to Rachels, endorsed by the American Medical Association. According to the conventional view, passive euthanasia is sometimes permitted, whereas active euthanasia is prohibited. Rachels in arguing against the conventional view refers to the statements made by the American Medical Association which states:

The intentional termination of the life of one human being by another--mercy killing--is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his

immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family. (as cited in Rachels, 1975 / 1994a, pp. 112-113)

The AMA's statement does not include terminology such as active and passive euthanasia. However, the way the statement is laid out refers to two categories: (1) termination of extraordinary medical treatment in face of irrefutable evidence that biological death is imminent and patients consent is favorable, and (2) the prohibition of intentional termination of the life of one human being by another. The meaning of the statement is matter of interpretation. The researcher holds that the statement does refer to active euthanasia and prohibits it and it does not refer to passive euthanasia as understood by Rachels. Rather, the statement refers to the cessation of the employment of extraordinary means to prolong the life. However, the passive euthanasia is used for convenience in this chapter due to Rachels's formulation of the statement.

Rachels's position against CDE is briefly summarized in the abstract of his famous article, *Active and Passive Euthanasia* as follow:

The traditional distinction between active and passive euthanasia requires critical analysis. The conventional doctrine is that there is such an important moral difference between the two that, although the latter is sometimes permissible, the former is always forbidden. This doctrine may be challenged for several reasons. First of all, active euthanasia is in many cases more humane than passive euthanasia. Secondly, the conventional doctrine leads to decisions concerning life and death on irrelevant grounds. Thirdly, the

doctrine rests on a distinction between killing and letting die that itself has no moral importance. Fourthly, the most common arguments in favor of the doctrine are invalid. I therefore suggest that the American Medical Association policy statement that endorses this doctrine is unsound. (Rachels, 1975/1994a, p.112)

Rachels in the following arguments attempts to show that the conventional view which permits passive euthanasia, in fact, leads to permissibility of active euthanasia. The ultimate goal of his arguments is that there is no moral difference between active and passive euthanasia, and where passive euthanasia is permitted, active ought to be permitted, but preferred too. In arguing against the positions taken in the AMA's statement, Rachels proposes four challenges as follows:

2.3.1. Often Active Euthanasia Seems More Humane Than Passive

Rachels claims that active euthanasia seems more humane than passive euthanasia. Therefore, active euthanasia should not be only permitted but preferred. Rachels illustrates the above challenge by examples. He gives a few examples of patients who suffer unbearable pain and, therefore, he suggests that it would be better to kill such patients for the sake of ending their suffering. Rachels gives an example of a cancer patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request (Rachels, 1975/ 1994a, p.113).

Rachels considers the choices available in such a case which are: (1) keeping the patient alive with life-supporting equipment, in that case he will experience a few more painful months, (2) allowing the patient to die by removing the life-supporting equipment, instead of months it will be days, then (3) actively ending the patient's life, so that the pain will stop right away. Rachels holds that sometimes doctors and patients choose option (2), because they want to reduce the patient's pain. But, Rachels claims, option (3) does a much better job at eliminating pain. Rachels gives a few more examples to show that there are other cases where "allowing the patient to die" is much more painful and inhumane than active euthanasia (Rachels, 1975/ 1994a, p.113). Therefore, in such cases, Rachels claims that active euthanasia seems more humane than passive euthanasia.

2.3.2. The Conventional View Makes Life-And-Death Decisions on Irrelevant

Grounds

Rachels in support of the claim that the conventional view makes life-and-death decisions on irrelevant grounds, refers to the case of babies with Down syndrome. Babies with such kind of disease require a surgical operation. But in certain cases, parents refrain from having the child operated, as a result of which it will die. He utilizes a situation in which the child is also born with a congenital defect; in this case it is an intestinal obstruction. If the parents make the decision to deny operation and allow the baby to die naturally, the infant will most likely perish from dehydration and infection. Rachels points out that this painful process could be avoided through active euthanasia. He calls attention to the cruelty involved in permitting the child to suffer

when there is a lethal injection available that can put him out of his misery. Rachels draws the attention to the fact that if the lives of these infants are worth living, then their lives should be preserved. Therefore, he argues that “allowing to die” and “actively killing” would be equally wrong. Rachels concludes:

What makes this situation possible, of course, is the idea that when there is an intestinal blockage, one can “let the baby die,” but when there is no such defect there is nothing that can be done, for one must not “kill” it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is another good reason why the doctrine should be rejected. (Rachels, 1975/1994a, p.115)

2.3.3. There is no Moral Difference between Doing and Refraining

Rachels, before attempting to prove that there is no difference between doing and allowing, explores the commonsense point of view on the issue. He maintains that the reason why so many people think that there is an important moral difference between active and passive euthanasia is that they think killing someone is morally worse than letting someone die. Rachels questions the view and to investigate this issue, he suggests that two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Rachels gives the example of Smith and Johns as mentioned earlier under 2.2.2. Killing and Letting Die. In short, Rachels maintains that there is no moral difference between doing or allowing/ killing or letting die; and intentions are not morally relevant.

2.3.4. Arguments in Favor of the Conventional View do not Work

Rachels claims that the arguments given in favor of conventional view are unconvincing. He mentions the most common argument in favor of the conventional view: the important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death; and the patient dies of whatever ills already afflict him. In active euthanasia, however the doctor does something to bring about the patient's death: he kills him (Rachels, 1975/ 1994a, p.117).

Rachels responds to the above argument; he maintains that of course, one can be held responsible for something that one does not do. Rachels comments that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. Rachels states that the decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right or wrong. Rachels concludes that if a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient (Rachels, 1975/ 1994a, p.118).

2.4. Rachels's Arguments for Active Euthanasia

Rachels's arguments for active euthanasia are of types. The first type is based directly on his biological and biographical distinction as elaborated in the conceptual framework. The second type of arguments, by which he supports active euthanasia, is

the arguments which attempt to establish that the distinction between active euthanasia and passive euthanasia is morally absurd. Therefore, wherever passive euthanasia is applicable, active should be permissible as well. This has been shown in the second part of this chapter. The first two types of arguments can be classified as indirect arguments. The third type of arguments includes his direct arguments as elaborated in the following part of the chapter. Rachels states "I believe that it [active euthanasia] is morally justified in some instances and that at least two strong arguments support this position. The first is the argument from mercy; the second is the argument from the golden rule" (Rachels, 1981/ 1994b, p.146). He adds one more argument for the legalization of active euthanasia based on the right to liberty (Rachels, 1983). Briefly, this argument argues that dying people should be free to choose euthanasia as a matter of personal liberty and autonomy. The arguments are explained in the following part of the chapter.

2.4.1. The Argument from Mercy

Rachels believes that the single most powerful argument in support of euthanasia is the argument from mercy (Rachels, 1981/ 1994b, p.146). He claims that, it is also an exceptionally simple argument, at least in its main idea, which makes one uncomplicated point. Rachels explains that terminal patients sometimes suffer pain so horrible that it is beyond the comprehension of those who have not actually experienced it. Their suffering can be so terrible that we do not like even to read about it or think about it; we recoil even from the descriptions of such agony. The argument from mercy says: euthanasia is justified because it provides an end to that (Rachels, 1981/ 1994b, p.146). Rachels illustrates the above statement by a few examples, describing the pain of terminally ill patients. The argument is similar to Rachels's first

argument against CDE as mentioned earlier.

2.4.2. The Best Interests and Golden Rule Argument

Rachels while continuing the similar line of thought as in the mercy argument, attempts to forward two aspects of the same argument separately. The argument is admixture of the best interests and the golden rule. Rachels starts from the utilitarian argument in favor of active euthanasia, however, he states that if an argument is based on the mercy alone on the utilitarian grounds, the argument will be faulty due to the Principle of Utility as a premise of the argument. Therefore, Rachels tries to avoid such a problem and comes up with an alternative argument, which is inspired, according to Rachels, by utilitarianism, but which avoids the difficulties of the pure utilitarian version of the argument, by not making the Principle of Utility a premise of the argument. Therefore, Rachels provides the following argument based on doing what is in everyone's best interests, and he claims that the argument is sound and proves that active euthanasia can be justified:

1. If an action promotes the best interests of *everyone* concerned, and violates *no one's* rights, then that action is morally acceptable.
2. In at least some cases, active euthanasia promotes the best interests of everyone concerned and violates no one's rights.
- 3 Therefore, in at least some cases active euthanasia is morally acceptable.

(Rachels, 1981/ 1994b, p.149-150)

Rachels, after presenting the above argument, states the benefits of employing the argument in voluntary active euthanasia. His words in their tune and emotion are as

follows:

It would have been in everyone's best interests if active euthanasia had been employed in the case of Stewart Alsop's friend, Jack [a terminally ill patient who died in a painful death]. First, and most important, it would have been in Jack's own interests, since it would have provided him with an easier, better death, without pain. (Who among us would choose Jack's death, if we had a choice, rather than a quick painless death?) Second, it would have been in the best interests of Jack's wife. Her misery, helplessly watching him suffer, must have been almost equal to his. Third, the hospital staff's best interests would have been served, since if Jack's dying had not been prolonged, they could have turned their attention to other patients whom they could have helped. Fourth, other patients would have benefited since medical resources would no longer have been used in the sad, pointless maintenance of Jack's physical existence. Finally, if Jack himself requested to be killed, the act would not have violated his rights. Considering all this, how can active euthanasia in this case be wrong? How can it be wrong to do an action that is merciful, that benefits everyone concerned, and that violates no one's rights? (Rachels, 1981/ 1994b, p.150)

Rachels after presenting the above argument complements the argument by other argument inspired by the golden rule. Rachels's golden rule argument is actually the reinforcement of his best interest argument. Rachels states that Immanuel Kant incorporated the basic idea of the golden rule into his system of ethics. Rachels discusses the categorical imperative of Kant which says: act only according to that

maxim by which you can at the same time will that it should become a universal law. Rachels elaborates on the principle: “that we should act only on rules that we are willing to have applied universally; that is, we should behave as we would be willing to have *everyone* behave” (Rachels, 1981/ 1994b, p.151). Rachels while taking the careful analysis of the principle states that the basic idea behind the golden rule is a good one. He points out the following principle:

the basic idea is that moral rules apply impartially to everyone alike; therefore, you cannot say that you are justified in treating someone else in a certain way unless you are willing to admit that that person would also be justified in treating you in that way if your positions were reversed. (Rachels, 1981/ 1994b, p.151)

Rachels after going into explanatory details about the maxim, ultimately tries to explain the meaning of the maxim and its relation to the case of euthanasia as follows:

The application of all this to the question of euthanasia is fairly obvious. Each of us is going to die someday, although most of us do not know when or how. But suppose you were told that you would die in one of two ways, and you were asked to choose between them. First, you could die quietly, and without pain, from a fatal injection. Or second, you could choose to die of an affliction so painful that for several days before death you would be reduced to howling like a dog, with your family standing by helplessly, trying to comfort you, but going through its own psychological hell. It is hard to believe that any sane person, when confronted by these possibilities, would choose to have a rule

applied that would force upon him or her the second option. And if we would not want such a rule, which excludes euthanasia, applied to us, then we should not apply such a rule to others. (Rachels, 1981/ 1994b, p.151-152)

2.4.3. The Argument from Autonomy

Rachels's main arguments in favor of active euthanasia are basically and essentially based on the consent of the terminally ill patient, that the justification of such practice is based on the free will and autonomy of the patient and furthermore on the joint consent of the other parties involved as briefed in the aforementioned arguments. Therefore, the argument from autonomy in favor of voluntary active euthanasia stands as the foundation of Rachels's thesis which according to him is based on two strong arguments, the golden rule and the best interest arguments. The autonomy argument involves discussions on liberty, rights, self determination and conception of autonomy itself. Rachels in his works refers to all these concepts to gain more warranty for his argument.

Rachels's distinction between biological and biographical life shows that biological life is not the moral issue. Rachels view states that life is not intrinsically valuable, the moral issue is about having a biographical life (Rachels, 1986b, p. 5). Biographical life entails that a human being is an autonomous being. Therefore, if a person autonomously chooses to end his or her life or have someone else assist him or her in doing so, then it is morally permissible. One should be free to do as one chooses as long as no harm is done to others. In supporting the position, Rachels develops a further argument for the legalization of active euthanasia based on the right to liberty.

Briefly, this argument is that dying people should be free to choose euthanasia as a matter of personal liberty. The supporting argument frequently advanced in support of legalization of active voluntary euthanasia proceeds by way of analogy to the law of suicide. Rachels also supports his position by the same argument. The argument begins with the proposition that since it is not unlawful for a person to commit or attempt to commit suicide, the law, implicitly at least, recognizes the right of an individual to take his or her life. From this premise it is argued that if an individual does have the right to take his or her life, he or she should be able to seek the assistance of others in achieving this end (Rachels, 1983, p.19). It should be noted here that Rachels refers to the American criminal law. Furthermore, Rachels's arguments such as the golden rule and the best interest argument are based on the same notion of autonomy that if a terminally ill patient chooses euthanasia as his best interest, such a patient should be granted his wish.

2.5. Proposal for Legalization of Active Euthanasia

Rachels proposes what he calls the modest proposal for the legalization of active euthanasia. Before proposing such a proposal, Rachels makes some elementary points about American law. He states that according to the American law individuals charged with a crime have no obligations to prove their innocence. Instead of that, the burden of proof is on the prosecution, and if the prosecution has not discharged its obligation to prove guilt, the jury's duty is to acquit the defendant. However, if the prosecution does establish a strong case against the defendant, a more active defense is required. In such a case, Rachels states that there are two options available.

The defendant may deny having done the criminal act in question. Or, while admitting to the act, the defendant may nevertheless argue that he or she should not be punished for it. Rachels further elaborating on the second case that there are two legally accepted ways of arguing that a person should not be punished for an act even while admitting that the act is prohibited by law and that the person did it. First, an excuse may be offered, such as insanity, coercion, ignorance of fact, unavoidable accident, and so on. He states that in case of successfully proving any of the grounds then the defendant may be acquitted. Second a justification may be offered. A plea of self-defense against a charge of murder is an example of a justification that you were insane or that the killing was a tragic accident for which you are blameless or that you had to kill him in self-defense. If none of these defenses can be made out, then you will be acquitted of the crime even though you admittedly did kill the victim.

Rachels therefore concludes that it is not quite accurate to say that under American law the burden of proof is always on the prosecution. If the defendant concedes to having performed the act in question but claims an excuse or justification for the act, the burden of proof may shift so that the defense is required to show that he excuse or justification should be accepted (Rachels, 2003).

Rachels while using the above fundamental procedure in the criminal trials in American courts proposes a legal scenario in which there is legally a successful possibility of making active voluntary euthanasia a reality without any adverse repercussions to the physician who performs such an act.

Rachels states that proposal for legalizing active euthanasia is that a plea of

mercy killing be acceptable as a defense against a charge of murder in much the same way that a plea of self-defense is acceptable as a defense. He further elaborates that under his proposal, "someone charged with murder could also plead mercy killing; and then if it could be proven that the victim while competent requested death, and that the victim was suffering from a painful terminal illness, the person pleading mercy killing would also be acquitted" (Rachels, 2003). Rachels while explaining the above procedure mentions that under the above proposal no one would be "authorized" to decide when a patient should be killed. He adds that "there are no committees to be established within which people may cast private votes for which they are not really accountable; people who choose to mercy kill bear full legal responsibility, as individuals, for their actions" (Rachels, 2003).

How the above procedure would be practically applicable to the cases of voluntary active euthanasia, Rachels explains the practicality of the case as follows:

In practice, this would mean that anyone contemplating mercy killing would have to be very sure that there are independent witnesses to testify concerning the patient's condition and desire to die; for otherwise, one might not be able to make out a defense in a court of law - if it would come to that - and would be legally liable for murder. However, if this proposal were adopted, it would not mean that every time active euthanasia was performed a court trial would follow. In clear cases of self-defense, prosecutors simply do not bring charges, since it would be a pointless waste of time. Similarly, in clear cases of mercy killing, where there is no doubt about the patient's hopeless condition or desire to die, charges would not be brought for the same reason. (Rachels, 2003)

Rachels after proposing the above proposal claims that under the proposal, the need to write difficult legislation permitting euthanasia is bypassed. He further explains that by following the above proposal “we would rely on the good sense of judges and juries to separate the cases of justifiable euthanasia from the cases of unjustifiable murder, just as we already rely on them to separate the cases of self-defense and insanity and coercion” (Rachels, 2003).

CHAPTER THREE

Critique of Rachels's Thought on Euthanasia

3.1. Introduction

The criticism of Rachels's thought on euthanasia is the subject of this chapter. The arguments developed by Rachels are addressed. The chapter analyzes firstly, the conceptual framework of Rachels and demonstrates its inadequacy on conceptual and practical basis ; secondly, it demonstrates the theoretical problems in Rachels's arguments which attempt to prove the distinction between active and passive euthanasia is morally absurd , therefore, the criticism leads to invalidity of the validity of active euthanasia on the basis of the permissibility of so called passive euthanasia, and thirdly, it criticizes Rachels's arguments for active euthanasia by showing their weaknesses which affect their soundness. In addition, the researcher also shows the problems in Rachels's proposal on the legalization of active euthanasia which renders his proposal problematic and impractical. And, lastly, the researcher debates that there is only one type of euthanasia which is active euthanasia and which ought to be rejected, due to unjustifiability of Rachels's arguments, and due to reasons that the cases of active euthanasia are medically mishandled patients whose death is unnecessarily prolonged by the use of advanced medical technology. Furthermore, the researcher demonstrates that passive euthanasia in the sense of "letting die" is not euthanasia. Passive euthanasia is an invented name for natural death and it is misconstrued as passive euthanasia by creating confusion between letting die and withholding, withdrawing and terminating extraordinary medical treatment. Finally, the researcher shows that Rachels's active and passive dichotomy is a false dichotomy.

3.2. Criticism of Rachels's Conceptual Framework

Rachels's conceptual framework includes few distinctions: (1) biological and biographical life; (2) killing and letting die; and (3) ordinary and extraordinary medical treatment. On Rachels's view, these distinctions allegedly substantiate his claim for active euthanasia; however, most of the distinctions make sense only if passive euthanasia is accepted permissible. Moreover, these distinctions make premises of Rachels's proposed arguments; therefore their analysis and criticism directly affects the validity of his given arguments.

The following part of the chapter deals the above distinctions respectively. The researcher substantiates the claim that Rachels's conceptual framework has various problems which are reasonably not enough to support the soundness of his position and that of arguments which mainly draw on such concepts.

3.2.1. Criticism of Biological and Biographical Life

In brief, Rachels makes a distinction between biological and biographical life. Biological life is merely being a living being; whereas biographical life is the sum of one's characteristics which are: (1) aspirations, (2) decisions, (3) activities, (4) projects, and (5) human relationships; and theses characteristics are valuable for a person and their loss would harm that person. Therefore, Rachels states that only biographical life is morally relevant (Rachels, 1986b, p. 526, 38). Consequently, Rachels argues for active euthanasia on the basis of the distinction (Rachels, 1986b, p. 54).

In spite of the simplicity of the above distinction, the following study shows that the distinction between biological and biographical life does not provide a valid foundation or criteria for the permissibility of active euthanasia. The distinction is rather inadequate due to: (1) reductive fallacy “oversimplification”; (2) slippery slope and (3) inconsistency with the main arguments of Rachels.

The first reason is that Rachels's distinction of biological and biographical life leads to reductive fallacy; he oversimplifies the human nature. The main implication of the above distinction is that a human person is defined in functional terms and such a definition is indefensible both conceptually and practically. From Rachels's distinction it appears that the biographical life, according to Rachels, is a set of capacities an entity with biological life should possess. This analysis and the distinction of biological and biographical life are actually aimed at having a definition of a human person in functional terms. As a matter of fact, Rachels in holding such a view is not alone; in the same manner, ethicist like Mary Ann Warren draws a more sophisticated demarcation between so-called “genetic humanity” and “moral humanity”, claiming only those in the latter group are persons. Persons, she claims, must meet one of five criteria: (1) consciousness; (2) reasoning; (3) self-motivated activity; (4) the capacity to communicate; and (5) the presence of self-concepts (Warren, 1996). Likewise, Joseph Fletcher adds the capacities: (1) self-control; (2) a sense of the future and the past; (3) the ability to relate to others; and (4) curiosity (Fletcher, 1972). As a result, on this view, the definition of a human person relies on certain properties, capacities, and functions.

The above functional view is basically derived from Rene Descartes or John Locke. Descartes's "cogito, ergo sum" shows what is to "be"; he claims that a thing cannot exist without its essential components but being united with the human body in the proper sense is no part of the essence of mind (Descartes, 1931, p. 97). Likewise, Locke defines a person as a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing in different times and places by that consciousness, which is inseparable from thinking (Locke, 1894, p. 246). According to Descartes and Locke a human person is someone who is actually acting at the time in a rational manner. In short, if one is acting rationally one is a person. On the contrary to the above view, there are philosophers on the opposite side. Aristotelian and Thomastic position argues that there is no distinction between a human person and a human being; they are inseparable. According to Aristotle, the human being is defined as one composite substance - the vegetative, sensitive and rational powers of the soul together with the human body. The whole soul is homogenous, and in each part of the body as one whole composite; this means that the several parts of the soul are indiscoverable from one another (as cited in Irving, 1993, endnote. 38). For Thomas Aquinas the name of person does not belong to the rational part of the soul, nor to the whole soul alone - but to the entire human substance. He further explains that human being is a human person, and the later characteristics, such as rational attributes, autonomous willing or sentience, are only consequential and secondary or accidental actions which follow upon certain powers, not parts, which themselves follow upon the essential nature of the human being itself (as cited in Irving, 1993, endnotes.42, 43).

The above two opposing trends of thought on divisibility of a human being has been the center of the philosophy of mind; the discussion in the philosophy of mind revolves around the distinction between “mind” and “body”. This conceptual divisibility has taken different names and in a derived sense the distinction of “human being” and “human person” belongs to the same category. The survey of this distinction in the philosophy of mind shows that substance dualism is a discredited position, and the rest of the positions are either inclusive of or reduced to material or biological substance. Thus, these theories, in aggregate, lead to the conclusion that the above mentioned distinctions could be made conceptually but not physically.

The abovementioned conflicting views show that even conceptual demarcation between a human person and a human being could not be demarcated precisely; however the practical aspects of such conceptualization are ethically relevant to the modern developments such as euthanasia and abortion. Therefore, any derivation on the conceptual distinction of a human entity for justifying the matters of life and death has practically indefensible consequences. The definition of a human person in functional terms by ethicists like Rachels, Mary Ann Warren, and Joseph Fletcher, is not a matter of conceptual hair splitting but of practical nature.

From the functional definition of personhood, it follows that essential personhood is a degreed property. Therefore, it is undeniable that the first several years of normal life outside the womb include an increasing expression of human capacities. Likewise, the last several years of life may include a decreasing expression of human capacities. Consequently, if the functionalist view is correct, the possession

of personhood could be expressed by a bell curve, in which a human being moves toward full personhood in her first years of life, reaches full personhood at a given point, and then gradually loses her personhood until the end of her life. Presumably, the commensurate rights of persons would increase, stabilize and decrease in the process. Without appealing to something other than function, it is difficult to resist this counterintuitive conclusion. Indeed, intellectual honesty has driven many to embrace this conclusion, and the slope is ever so slippery. In the same manner, Helga Kuhse and Peter Singer comment on the ontological status of newborns:

. . . . When we kill a newborn, there is no person whose life has begun. When I think of myself as the person I am now, I realize that I did not come into existence until sometime after my birth. . . . It is the beginning of the life of the person, rather than of the physical organism, that is crucial so far as the right to life is concerned. (as cited in Mitchell & Rae, 1996, p. 30)

Furthermore, if the functional model is true, then the mentally ill and retarded, drug and alcohol addicts and patients with Parkinson's and Alzheimer's diseases are not persons. The threat is that such model has potential of including the various types of people with disabilities or diseases. Now it must be admitted that these arguments apply to the newborn baby as much as to the fetus. And philosopher Richard Frey pushing Singer's logic one step further, suggests that mentally ill human beings are therefore also not "persons", and therefore they might be used in purely destructive

experimental research in place of the higher animals who are "persons"(as cited in Irving, 1993, endnote.97).

The oversimplification of a human being in the terms of capacities as described above becomes more troublesome and slippery if Rachels's distinction is applied in deciding life and death matters. According to Rachels the importance of a biographical life is that a person has the capacity to set and achieve goals, plans, and interests that are important from the point of view of the individual. To better grasp this, consider Rachels's treatment of the 1973 "Texas burn case" where a man known as Donald C. was horribly burned but was kept alive for two years in the hospital against his will, and is still alive today. Rachels believes this man's desire to die was rational because he had lost his biographical life. Rachels suggests:

Now what could be said in defense of the judgment that this man's desire to die was rational? I believe focusing on the notion of his *life* (in the biographical sense) points us in the right direction. He was, among other things, a rodeo performer, a pilot, and what used to be called a "ladies' man." His life was not the life of a scholar or a solitary dreamer. What his injury had done, from his point of view, was to destroy his ability to lead the life that made him the distinctive individual that he was. There could be no more rodeos, no more aeroplanes, no more dancing with the ladies, and a lot more. Donald's position was that if he could not lead *that* life, he didn't want to live. (Rachels, 1986b, p. 54)

As illustrated in the above example, it appears that Rachels's definition of

the biographical life is a very loose definition. The definition does not only justify mercy killing for suffering terminally ill patients, but also its inclusiveness justifies killing any one who by the definition seems to fulfill the requirements. Therefore, euthanasia on such formulation is not only for terminally ill patients as Rachels argues in his works but for those non terminally ill patients too, who have lost hope or by some misfortune could not live the life they strive for. The other aspect of this definition is that if the definition is decisive on life and death of a person then many other persons besides terminally ill patients will lose right to life involuntarily. Therefore, Rachels's distinction of biological and biographical life fails as the distinction entails more than what Rachels's work demands and accepting such a distinction becomes easy target to slippery slope. Therefore, the distinction on its own is not sufficient enough to declare a human being impersonal. As a matter of fact, from the practical point, the Dutch scenario attests the above inevitable consequences. Herbert Hendin, of the American Foundation for Suicide Prevention, and two Dutch colleagues, writing in the *Journal of the American Medical Association* (June 4, 1997), maintains that Holland is already sliding down the "slippery slope." In recent decades, they write, "the Netherlands has moved ... from euthanasia for terminally ill patients to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to non-voluntary and involuntary euthanasia" (Hendin, 1997, pp. 128-130).

Nevertheless, Rachels's distinction of biological and biographical life makes sense in the cases when a dying patient is kept alive by the employment of

life sustaining machines, however, in such a case killing actively is not the only option, in such a case, the extraordinary medical treatment can be withdrawn or withheld. Therefore, active euthanasia becomes unnecessary. Moreover, further problem which emerges from the distinction is that the generality of the distinction leads to abuse of patients on wider scale.

Again, even though the distinction of biological and biographical life is supposed to be valid on its own, as a result, problems emerge in Rachels's thought, because the distinction defines a human person in way which is not coherent with the main arguments of Rachels which are based on patient's consent and autonomy. The distinction, consequently, leads to permissibility, not only of voluntary active euthanasia, but also of non-voluntary and involuntary. Although, Rachels advocates only for permissibility of voluntary active euthanasia in his main arguments, but his distinction entails the consequences which hardly seem to escape being the easy target of slippery slope. If the distinction is sufficient, then any need of patient consent becomes irrelevant. Therefore, the distinction leads to inconsistency and incoherence in Rachels's thought, and the distinction becomes irrelevant to Rachels's main arguments for active euthanasia, which are best interest and golden rule argument and autonomy argument. And both these arguments are based on patient consent and autonomy.

3.2.2. Criticism of Killing and Letting Die

Killing and letting die distinction in other words could be formulated as omission and commission. Rachels argues that there is morally no distinction between

killing someone and letting someone die. The implication of the distinction is related to the active and passive dichotomy. Rachels by applying above concept attempts to show that the active and passive dichotomy is a distinction without difference. He calls it the equivalence thesis, and the main argument for it is called the bare difference argument: Rachels hypothesizes two cases that are supposed to be exactly alike except that one involves killing and the other involves letting die. Rachels uses the distinction in many arguments to force his viewpoint. The distinction is very vivid in his arguments such as mercy argument, bare difference argument and etc.

The researcher's counter position to Rachels is that the distinction between killing and letting die is: (1) irrelevant, (2) extraneous to the medical profession, and methodologically degressive.

3.2.2.1. Killing and Letting Die: An Irrelevant Distinction

The killing and letting die discussion is both relevant and irrelevant to the issue of euthanasia. The relevance could be made when a doctor intentionally withdraws or withholds the treatment to kill a curable patient; and if such treatment is continued the patient will live healthy. Thus, in this case there is no difference between killing and letting die. The distinction is irrelevant to euthanasia because it is not the case that doctors let the patient die with the intention of killing. The researcher's main claim is that though killing and letting die may be of importance in various moral issues, however the distinction is itself irrelevant to the issue of euthanasia. The distinction is unnecessarily brought into the debate on euthanasia to support killing on the basis of "letting die", whereas in fact letting a patient die

intentionally is not supported by doctors or practically found happening. The distinction misrepresents the act of withholding, withdrawing and terminating extraordinary medical treatment, and equates it with letting die. From the very commonsense point of view, one can save a dying person if the person is in the range of recovery and when such a person is out of such a range, it is not possible to save such a person and death of such a person could not be termed as 'letting die'. The following very simple hypothetical example shows the issue clearly:

Jason was walking on a bridge which is over a deadly river and suddenly he heard a bomb explosion. He found that the people were running and falling. The walls of the bridge were destroyed. He found on his right a person, Adam, who was hanging there grabbing the destroyed wall of the bridge and was about to fall into the river. On Jason's left was Peter who had just fallen from the bridge and was crying, falling toward the river and was out of Jason's reach. Jason hopelessly looking at falling Peter gave his hand to Adam and rescued him.

In the above example the following two cases could be made:

1. Jason saved Adam, because Adam was about to fall and die, however it was possible for Jason to rescue him. Should Jason be praised for his action or should he be blamed for not letting Adam die?
2. Jason saw that Peter had already gone out of his reach and was falling to the river. Should Jason be blamed for letting Peter die?

The response to (2) is clear that Jason did not let Peter die. It was not possible for him to save him because Peter had gone out of his reach. The same happens in the

hospitals where a person with a curable disease is saved and those who are incurable with deadly disease are left on their own with some help which could minimize their suffering. Rachels treats the issue as letting die. Whereas, the fact is that doctor did not let the patient die; he simply could not do anything about it. Nevertheless, if a doctor withholds the treatment from a patient who suffers a curable disease and dies due to doctor's negligence or refusal of treatment, in such a case, it could be claimed that letting die takes place. Rachels confuses both these cases and tries to make his point by claiming that the doctor let the patient die in the first case.

The AMA's statement actually holds that it is not allowed to kill a patient and if the medical treatment seems hopeless and useless, in such a case the patient has choice to refuse the extraordinary treatment. As the treatment apparently is not going to show any improvement in the health condition of the patient, the doctor and the patient, both have reason to agree on termination of medical treatment. The future of the patient remains hidden with possibilities in the future, and the possibility of patient's recovery from the disease could not be just anticipated as impossible, the evidence to contrary shows that there are such patients who have recovered after certain time.

Basically AMA's statement involves two choices: (1) that it is impermissible for the doctor or anyone else to terminate intentionally the life of a patient, but (2) that it is permissible in some cases to cease the employment of "extraordinary means" of preserving life, even though the death of the patient is a foreseeable consequence (Sullivan, 1994a, p. 132). The first choice could be classified as active euthanasia, it

includes actively killing a patient and AMA's statement prohibits it. The (2) choice deserves a clarity. Rachels tries to classify the second option as passive euthanasia and his definition of passive euthanasia literally means letting die. However, as shown in the above example the (2) is not passive euthanasia in the sense Rachels treats it. Therefore, the application of killing and letting distinction to euthanasia is irrelevant.

3.2.2.2. Killing and Letting Die Distinction and Health Care Professions

The distinction between killing and letting on the wording of Rachels is that in passive euthanasia a patient is killed by letting him die and in active euthanasia a patient is killed and both these acts are due to the terminal illness of the patient. Therefore, killing and letting die are the same and if passive euthanasia is allowed, active should be permitted too.

Rachels's understanding of the distinction of killing and letting die is actually inspired by a certain legal and moral understanding of the omission and commission distinction. The legal position on the distinction varies in different countries and legal systems. Ernest S. Weinreb (1980) states that in Anglo-American common law unlike many other legal systems, no general duty requires a passerby to render a stranger affirmative assistance. Despite the legal tradition, many in America and England passionately argued that anyone who failed to render assistance should be prosecuted. Some American states, including Vermont, Minnesota, and Rhode Island, have adopted statutes requiring strangers to provide affirmative assistance to persons in distress when they can do so without harm to themselves (as cited in Gorsuch, 2000,

footnote. 239); however, the legal and moral standing on the issue in special professions is different. The professional situation where a special relationship exists, and the patient-physician setting is a paradigmatic example, omissions of ordinary care are as punishable as affirmative misdeeds. Indeed, a physician's omission of readily available treatment is clearly a professional malpractice.

In light of the above, the distinction of killing and letting die is very extraneous to the medical profession. If the distinction is allowed to find its acceptance into the discipline, it would lead the profession to the wrong side; literally the profession will become not only life saving but also life taking. As a result, life care professions will be endangered. The application of the distinction becomes irrelevant to the professions meant for life caring such as life-guards, fire-fighting, health care, child care and early child-hood centers such as nurseries, and baby care centers etc. Here particularly, health care needs a special discussion. Health care or medicine develops from the objective to save lives and not to take lives. Killing or letting die a patient changes the definition of the profession itself. The severity of the issue has given a serious concern to doctors in the field of medicine as follows:

This issue touches medicine at its very moral center; if this moral center collapses, if physicians become killers or are even merely licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty. For if medicine's power over life may be used equally to heal or to kill, the doctor is no more a moral professional but rather a morally

neutered technician. (Gaylin, Kass, Pellegrino, & Siegler, 1989, p. 26)

Besides the irrelevance of the distinction to the nature of medical profession, the introduction of the distinction into the profession violates many other foundations and historical professional grounding of the profession; as first of all it grows the mistrust and suspicion between the patient and the doctor and secondly this kind of intrusion is not without other repercussions which freely lead to slippery slope and, in consequence, elderly people would be eliminated not just because of the reason of health but of economy. Moreover, the distinction will have adverse psychological impact on patients; “the patient can no longer look at his physician as his advocate for the extension of life—because when in the mind of that physician that patient's life is waning, the sick person has no guarantee that the physician will approach him in the role of life preserver; he may be coming as executioner” (Koop, 1976/ 1989a, pp. 82-83).

The relationship between a doctor and patient is professionally that a patient submits himself to a doctor and entrusts him his life. In such a relationship the doctor takes the patient through many stages with the hope to save his life. The following statement clearly depicts the doctor's role in handling the patients at various stages of the health conditions.

I am in the life-saving business and that comes first, but I recognize also that I am in the business of alleviating suffering. I never take a deliberate action with the motive of terminating a patient's life. It is possible that a patient's life might be shortened by some therapeutic measure I employ with the intent

of relieving suffering. In some circumstances where I believe that I have sufficient experience and expertise with the life history of a disease process and my patient's response to that disease as well as to his therapy, I might withhold treatment that could be considered extraordinary or heroic in the given circumstance in reference to the quality of life that might be salvaged for a short period of time. (Koop, 1976/ 1989a, p. 83)

Gay-Williams (1979/1989) while criticizing permissibility of euthanasia on practical grounds, states that doctors and nurses are, for the most part, totally committed to saving lives. Their failure in saving a life is like a personal failure and an insult to their skills and knowledge. He refers to the possibility that euthanasia as a practice might well alter this. Moreover, it could have a corrupting influence so that in any case that is severe doctors and nurses might not try hard enough to save the patient. They might decide that the patient would simply be "better off" dead and take the steps necessary to make that come about. He concludes that this attitude could then carry over to their dealings with patients less seriously ill. The result would be an overall decline in the quality of medical care (pp. 100-101). Gay-Williams said concern leads to other concern which is methodologically of crucial importance to the medical profession. It is a well known fact that the diseases which are easily curable in our time are the same diseases which were considered fatal at some point of the history. It is due to hard efforts of medical scientists that their cure became possible. Against this history of achievements in the medical science, if Rachels's distinction of killing and letting die is positively considered in the practice of medicine, it will lead to methodological problems into the discipline. There is possibility that those

patients who are suffering from deadly diseases will be killed and the effort needed to help such cases will not be spent. So the introduction of the distinction into medical practice creates two main problems one is that it changes the definition of the profession and such definition creates other problems such as mistrust between the patient and the doctor, secondly it removes the skeptic nature of scientific methodology which is progressive and the distinction aims at terminating every odds without making any effort to find any solutions.

3.2.3. Criticism of Ordinary and Extraordinary Means of Treatment

Rachels while finding flaws in the American Medical Association's policy statement claims that the statement states that life sustaining treatment may sometimes be stopped if the means of treatment are "extraordinary", Rachels adds, the implication is that "ordinary" means of treatment may not be withheld. To above position, Rachels states that, however, upon reflection it is clear that it is sometimes permissible to omit even very ordinary sorts of treatments (Rachels, 1981/ 1994b, p.143).

Rachels debates the definitions of ordinary and extraordinary forwarded by Paul Ramsey and supported by Thomas Sullivan. Rachels criticizes the definition is useless. He states that two problems regarding the distinction and shows that the distinction is senseless. He firstly criticizes the way the word "excessive" functions in these definitions. Secondly, Rachels turns to the use of the word "benefit" in the definitions. Rachels concludes that if the distinction is applied in a "straightforward, commonsense way, the traditional doctrine is false, for it is clear that it is sometimes

permissible to omit ordinary treatments. On the other hand, if we define the terms as suggested by Ramsey and Sullivan, the distinction is useless in practical decision making” (Rachels, 1981/ 1994b, p. 145).

In response to Rachels, the researcher argues that Rachels's claim against AMA's statement is not valid. There are two reasons to support such a claim: (1) AMA's statement does not make any distinction between ordinary and extraordinary medical care and (2) the distinction of ordinary and extraordinary is useful in practical decision making.

The first reason as stated above is that AMA's statement does not make a distinction between ordinary and extraordinary medical treatment. The statement is rather carefully worded; it mentions only “the cessation of the employment of extraordinary means to prolong the life”. The statement does not mention what is ordinary and what is extraordinary. The fact is that there is always something extraordinary about everything. And, what Rachels thinks is ordinary, may in fact be extraordinary, and vice versa. The drafting committee of the AMA's statement has shown sharpness and wisdom in avoiding any demarcation between ordinary and extraordinary medical treatment. Professionally, what could be classified as ordinary and extraordinary in the medical treatment is by no means a layperson's game. Even the most ordinary aid such as food and water could become extraordinary in circumstances when a person is fed by tubes in a vegetative state. Therefore, the demarcation of ordinary and extraordinary should be left to the experts of the field as the researcher considers it in the second reason.

The second reason is that the distinction between ordinary and extraordinary medical treatment is valid and useful. The fact is that the definition of ordinary and extraordinary is evolutionary in its content. Technologically, medicine has advanced so quickly that older, unwritten understandings of "ordinary" and "extraordinary" care no longer seem applicable. What might have been considered "extraordinary" care a few years ago is now so commonplace as to be called "ordinary" - respirators, pacemakers, kidney dialysis machines, etc. The following example is very suitable in discerning the nature and meaning of ordinary and extraordinary medical treatment.

If one had acute appendicitis and postoperatively developed a situation where his kidneys did not function, to put him on a dialysis machine (an artificial kidney) which could handle his urinary function temporarily would be an extraordinary act and might at times be considered to be "extraordinary" care. However, in a vigorous, alert, productive individual with a normal life expectancy of several decades ahead of him, it should not be considered "extraordinary" care. On the other hand, if in a ninety-year-old individual the same kidney shutdown took place and was the result of a disease process that inevitably would take this patient's life, the institution of dialysis would be an "extraordinary procedure" and would definitely be thought of, by any medically competent individual, as providing "extraordinary" care. (Koop, 1976/ 1989a, pp. 72-73)

The above example shows that the difference between ordinary and extraordinary treatment is a matter of physician's experience, it would most of the

time depend on many factors such as the condition of the patient, and to what level a patient would be able or viable to bear the expenses of in case any expensive aid or treatment is required. Rachels's view that there is no demarcation between ordinary and extraordinary treatment is therefore an uneducated guess. The distinction between ordinary and extraordinary treatment depends on the wisdom of a physician what his prudence would lead to. It is worthwhile to quote Max J. Charlesworth as follows:

But while there is obviously something in this distinction [ordinary and extraordinary] it is, as we have seen, a relative and variable one. In fact, it is rather like the legal criterion of 'the reasonable man'. In certain cases we ask ourselves, 'What would the reasonable man have done?' or 'How would the reasonable man have acted in this situation?' We are all aware that this is a very rough and ready criterion since what the 'reasonable man' would have done in Victorian times in the nineteenth century is clearly very different from what the 'reasonable man' might do in our present enlightened and liberated times. Again, what the Anglo-Saxon 'reasonable man' might do will be very different from what the Turkish or Greek 'reasonable man' might do. Nevertheless the criterion works in a rough and ready way at the practical level. (Charlesworth, 1989, pp. 65-66)

The second objection which Rachels poses to ordinary and extraordinary treatment is about the use of the word "benefit" in the definitions. It is said that ordinary treatments offer a reasonable hope of benefit for the patient; and that treatments are extraordinary if they will not benefit the patient. "Rachels notes that

how do we tell if a treatment will benefit the patient? Again, the point is that in order to decide whether life-sustaining treatment is a benefit we must first decide whether it would be a good thing for the life in question to be prolonged”(Rachels, 1981/ 1994b, p. 145). The objection of Rachels could be responded by stating that first of all the distinction between ordinary and extraordinary firstly depends on the prudence of the practitioner as stated above and secondly it appeals to the severity of the condition a patient goes through. The benefit of the care to the patient's health condition is what is a real matter a doctor should be concerned about not what Rachels suggests. Should “the life in question to be prolonged’ is something very judgmental on life and death and a doctor is not supposed to be judging that. “It must always be clear that the doctor's role is not to assess the value or worth of the *patient* but that of the *treatment*’ (British Medical Association, 1999/ 2007, p.8). The real concern a doctor should have is that will the available care to patient make an ordinary or extraordinary treatment. Therefore, Rachels's claim is normatively unjustifiable because the benefit of the care to the patient's health condition is what is a real matter a doctor should be concerned about; deciding the life and death of the patient puts the physician in an unwarranted prerogative role which is problematic due to legal complexities, rights, duties, and autonomy. Such a judgmental role is also prone to abuse and corruption. Therefore, the doctor's role is not to assess the value or worth of the patient but that of the treatment.

3.3. Criticism of Rachels's Arguments against Traditional Doctrine on Euthanasia (TDE)

Rachels argues against the traditional doctrine on euthanasia (TDE) or conventional doctrine on euthanasia (CDE) which is also called as conventional view or standard view which makes a distinction between active and passive euthanasia. This view, on Rachels's understanding, is upheld by the American Medical Association. According to Rachels the conventional view, passive euthanasia is sometimes permitted whereas active euthanasia is never permitted. It is necessary to note here that AMA's statement which is the actual target of Rachels's criticism does not make such a distinction. The statement disallows intentional killing of terminal patients and permits the termination of extraordinary medical care, in doing so the statement allows the cessation of medical treatment in extraordinary cases.

In arguing against CDE Rachels gives four arguments which on his formulation render the distinction between active and passive euthanasia morally absurd. Therefore, Rachels tries to prove that whereas passive euthanasia is allowed active euthanasia should be permitted too. The arguments are explained in the second chapter of this research. In the following part of the chapter the researcher, after highlighting the main points of Rachels's arguments, criticizes the arguments respectively.

3.3.1. Criticism of that often Active Euthanasia Seems More Humane than Passive

Rachels claims that often active euthanasia seems more humane than passive and therefore active euthanasia should not be only permitted but preferred too.

Rachels reinforces his position in mercy argument. He illustrates the claim by examples of terminally ill patients to show that 'allowing the patient to die' is much more painful and inhumane than active euthanasia (Rachels, 1975/ 1994a, p.113).

The logical form of the argument according to Don Berkich is as follows:

1. If CDE is true then passive euthanasia never produces more suffering than active euthanasia.
2. It is not the case that passive euthanasia never produces more suffering than active euthanasia.

Therefore

3. CDE is not true. (1& 2). (Berkich , 2003)

Rachels above argument mainly faces two responses which render his argument invalid. The first response is that Rachels argues against CDE on the basis not included in the AMA's statement. Rachels's argument against AMA's position is irrelevant. Rachels's arguments against CDE are actually supposed to be strictly against the text of the AMA' statement, whereas the above argument actually does not address the statement. The AMA's statement does not make difference because of pain or suffering. Therefore, Rachels's argument does not render the statement false

or invalid. According the AMA's statement, CDE is not based on suffering and no consideration is included on methods which produce less or more suffering. The validity test of the argument turns the argument invalid if the case is strictly considered against the AMA's statement. Because, AMA's statement makes the difference between killing and termination of extraordinary medical treatment. The suffering as such is not the part of the statement. Therefore, the argument does not give any problem to AMA's position.

The second response could be made if Rachels's argument is taken against CDE from the point of suffering as a separate argument with the content not considered in AMA's statement; that killing a terminally ill patient is better than leaving the patient suffer in pain. The argument from its simplicity, make a convincing point. However, the following arguments can be made against such an argument which render Rachels's argument unimportant, irrelevant, and inadequate.

The first point is that, though, a person is thought to be dying after a few days when such a patient is terminated from medical treatment as a potential subject to death, still the fact of "dying" is in the future. Will that patient die or live another few healthy years is not known as a matter of fact. There are cases in which the terminated person lived longer or healthier after being terminated from the treatment. To show how difficult predictions might be, *Medical World News* on May 5, 1974, reported a case of a woman with myasthenia gravis who lived "artificially" for 652 days in intensive care and then made a remarkable recovery. Said a hospital representative at the Harbor General Hospital in Torrance, California, "She made us

recognize that there was no such thing as inordinate effort. She had such a tenacity for life we felt that everything we did, no matter how extraordinary, was appropriate to the situation” (Koop, 1976/ 1989a, p.73). The case from the practical point goes against the active euthanasia, because recovery is a probability, therefore it is better to terminate the medical aid than actively kill a person. It is a well known fact that people have been known to recover from comas after considerable periods, and some terminally ill patients make miraculous recoveries. Allowing euthanasia would risk killing people who could otherwise have had years more life. With euthanasia the price of a mistake is too high. Philosophically, appeal to the future is itself a fallacy, arguing that evidence will someday be discovered which will, then, support your point. Now this appeal to the future as a fallacy applies to argument for active euthanasia instead of terminating extraordinary medical care. In case of terminating extraordinary medical treatment, the doctors withhold or withdraw the medical treatment on the conviction that the treatment is useless and the patient will die, whereas within the same conditions of conviction, in active euthanasia, the doctors kill the patient. It is the second case in which doctors, if allowed, are about to commit the fallacy as they take the future as a fact and granted.

The second point is that modern advanced medical technology has most developed treatment to control the pain or suffering of a patient. Therefore, the argument which states that a suffering person could be killed has no basis except that the medical care is not ready to support those ant-pain killing treatment.

The pain and suffering should they be the basis for deciding the permissibility

of active euthanasia, the case is contrary to what Rachels states. If the need of active euthanasia is due to suffering, but, on the other hand, suffering could be controlled by medication without actively killing a patient, therefore active euthanasia seems undesirable. With the highly effective painkillers now available there is never any need even for the terminally ill to suffer great pain. Use of painkillers, not euthanasia, is the answer to painful terminal illness. "[I]n up to 90 percent of [cancer] patients, the pain can be controlled by relatively simple means. Nevertheless, under treatment of cancer pain is common because of clinicians' inadequate knowledge of effective assessment and management practices, negative attitudes of patients and clinicians toward the use of drugs for the relief of pain, and a variety of problems related to reimbursement for effective pain management" (Jacox, Carr, & Payne, 1994, p.651-655).

The other connected issue is that if suffering is the basis for permissibility of active euthanasia then only terminally ill patients are not the only subjects of the active euthanasia, there are many patients with diseases and suffering who are not terminally ill. Kelley & Clifford (1997) reported that Edwin S. Schneidman, founder of the American Association of Suicidology, maintains that dying is not painful; it is the illness that causes the pain. However, an individual does not have to have a terminal illness to have intractable pain, to which many people with conditions such as arthritis and fibromyalgia will attest (as cited in Manetta & Wells, 2001).

The other important notion which is connected with suffering is the conception of suffering itself. The suffering can be physical and it can be mental or

psychological. The euthanasia supporters may claim the end to physical suffering but what about psychological suffering. If suffering becomes the basis for the permissibility of active euthanasia, then many patients who are not terminally ill but psychologically suffering or non-terminally ill patients, will be subjects of euthanasia as well. Therefore, suffering as itself is an inadequate reason for permissibility of active euthanasia. The other reason is that suffering is actually about the attitude. The argument from suffering reaches beyond medicine's responsibility and competence; it extends into metaphysical questions about the nature of human happiness and of what constitutes a meaningful life. To enlist a physician to achieve release from a meaningless life of suffering presumes that the physician is competent to judge what kinds of life is worth of living. The roots of suffering are more than physical. The degree to which people suffer and whether they find life empty or meaningful depend more on their attitude than on their physical condition (Gula, 1999a, pp.501-5).

From the practical point of view, suffering is irrelevant to the issue of euthanasia due to advances in palliative care. In many cases of terminal cancer the choice is no longer between dying in agony and deliberately ending one's life since appropriate palliative care enables such patients to live out their lives in relative ease and peace. However, while it may be true that in many cases one may die in such a way as to keep one's self-respect without taking measures to end one's life, there are surely many situations where a person might, for very good reasons, no longer wish to prolong his or her life. These cases are cited in Rachels's works also. He illustrates his arguments by such examples. However, the reason which renders such a position invalid is that the cases are of patients who were kept alive by extraordinary means;

their death was prolonged due to inappropriate use of advanced medical technology. One of the famous examples of such cases is of Karen Ann Quinlan (March 29, 1954 – June 11, 1985). When she was 21, Quinlan became unconscious after coming home from a party, and lapsed into a persistent vegetative state. After she was kept alive on a ventilator for several months without improvement, her parents requested the hospital discontinue active care and allow her to die. “Karen Ann Quinlan's parents, for example, believed that their daughter would not have wanted to live in a comatose, 'human vegetable', state for ten years. But, as we know, they were unable to get her physicians to discontinue her life-sustaining treatment” (Charlesworth, 1989, pp. 75-77). Karen's case is one of the most illustrated cases in the history of euthanasia. The analysis of her case clearly shows that she was kept alive in vegetative state for long time, had her life sustaining machines disconnected she could have died earlier without suffering herself and her parents. The point is that if a person could not be cured by ordinary medical treatment and providing extraordinary treatment to such a patient when death is foreseen would only create suffering. Unfortunately, Rachels has nothing to say about it in his works. He has not made any contribution in showing that the root cause of pitiful cases is actually mishandling of patients by advanced medical technology.

However, responding to above counter reasoning, Rachels can argue and he has actually argued that there are still patients, their death is foreseen and instead of killing them they are left to die and their dying process takes days and weeks in suffering. He therefore argues that such patients could have been better off by active euthanasia by putting end to their suffering. The researcher argues against it from two

reasons. The first as elaborated earlier is that pain killers and palliative care has made suffering irrelevant. The second reason is that those patients who are terminally ill and their life may be miserable due to the pain which is caused by illness. For such patients double doctrine effect opens the way and avoids any need of active euthanasia. Simply, those patients will go through their dying process and their pain will be controlled by medicine even though such medication may shorten their lives as a side effect, so the shortening life will be treated as a side effect and not as the intended consequence. This last solution which prescribes pain medication to painful terminally ill patients comes with the famous principle called as Doctrine of Double Effect (DDE).

There are many names for Doctrine of Double Effect (DDE) such as Principle of Double Effect (PDE), Rule of Double Effect (RDE), Double-Effect Reasoning (DER), and simply Double Effect. The mention of DDE is of paramount importance because of its use in practical medicine and its existence as a backbone for many arguments which propose pain medication to alleviate the suffering of terminally ill patients. Thomas Aquinas is credited with introducing the principle of double effect in his discussion of the permissibility of self-defense in the *Summa Theologica* (II-II, Qu. 64, and Art.7). According to him, “nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention” (as cited in McIntyre, 2004). The classical formulation of the principle requires fulfillment of four conditions if the action in question is permissible: (1) that the action contemplated be in itself either morally good or morally indifferent; (2) that the bad result not be directly intended; (3) that the good result not be a direct causal

result of the bad result; and (4) that the good result be "proportionate to" the bad result. Where all these conditions are met, the action under consideration is morally permissible despite the bad result (Solomon, n.d. Formulation of the Principle).

Though the doctrine has many applications; in particular, its application in treating terminally ill is widely accepted and traditionally practiced. The principle is used to justify the case where a doctor gives drugs to a patient to relieve distressing symptoms even though he knows doing this may shorten the patient's life. This is because the doctor is not aiming directly at killing the patient - the bad result of the patient's death is a side-effect of the good result of reducing the patient's pain. Many doctors use this doctrine to justify the use of high doses of drugs such as morphine for the purpose of relieving suffering in terminally-ill patients even though they know the drugs are likely to cause the patient to die sooner. The double effect doctrine, as applied in medicine, is based on two basic presuppositions: the doctor's motivation is to alleviate suffering; and the treatment must be proportional to the illness. The doctrine applies if 1) the desired outcome is judged to be good e.g., relief of suffering; 2) the bad outcome e.g., death of patient is not intended; 3) the good outcome is not achieved by means of the bad, and 4) the good outcome outweighs the bad (Cohen-Almagor, 2000, pp. 267-278). These conditions of the principle are well elaborated on practical grounds by Wanzer et al. (1989/1990); they suggest that in the patient whose dying process is irreversible, the balance between minimizing pain and suffering and potentially hastening death should be struck clearly in favor of pain relief. They recommend that pain medication should be given in whatever dose and by whatever route is necessary for relief. They further suggest that in extreme cases it

is morally correct to increase the dose, even though the medication may contribute to the depression of respiration or blood pressure, the dulling of consciousness, or even death, provided the primary goal of the physician is to relieve suffering. They suggest that however the proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness (p. 287).

It is therefore an accepted practice to use doctrine of double effect in such cases which contain suffering. Even in cases where death is imminent and pain cannot be minimized or eliminated through normally accepted dosages of medication, active euthanasia is not the only option. A doctor can give the necessary pain medication if the intent is solely to alleviate pain and not to kill, even if it can be foreseen that such an action will hasten death. In this case death is a foreseen, tolerated, but an unintended effect.

3.3.2. Criticism of the Conventional View Makes Life-And-Death Decisions on Irrelevant Grounds

Rachels claims that the conventional view makes life-and-death decisions on irrelevant grounds therefore the conventional view, CDE, is not true. In support of the claim he refers to the case of babies with Down syndrome. He emphasizes the cruelty involved in permitting the child to suffer when there is a lethal injection available that can put him out of his misery. Rachels draws the attention towards that if the lives of these infants are worth living, then their lives should be preserved. 'Allowing to die' and 'actively killing' would be equally wrong (Rachels, 1975/1994a, p.115). Rachels's point is that hence the babies are being left to die; it would

be for better to kill such babies and therefore terminate their suffering. The logical form of the argument according to Don Berkich is as follows:

1. If acting in accordance with CDE leads to decisions about passive euthanasia being made on irrelevant grounds, then CDE is false.
2. Acting in accordance with CDE leads to decisions about passive euthanasia being made on irrelevant grounds.

Therefore

3. CDE is false. (1&2). (Berkich , 2003)

What exactly are the irrelevant grounds which Rachels is trying to show? The grounds which seem irrelevant to Rachels are killing and letting die on the basis of suffering. To him relevant ground ought to be suffering of the patient which should be considered in deciding the killing of a patient; that the suffering is what should allow a doctor to eliminate a human being actively and what minimizes that suffering should be the relevant ground. The researcher thinks that the case is somehow different. The relevant grounds in CDE are the ordinary and extraordinary medical care; there is no mention of suffering at all. The CDE makes case clear that when doctors are hopeless about the recovery of a patient; then such doctors can discontinue the treatment. Had the CDE being based on minimizing suffering, Rachels argument would have won the case from the utilitarian point of view. Simply, it could be argued that the premise 2 in the argument is false as the relevant ground for passive euthanasia in CDE is relevant and that is confirming that the employed health care is useless and most expectedly the patient will die as a natural course. The

concept of suffering in the whole debate seems an interesting invention by Rachels. His whole thought is based on the same grounds. In every argument he would be appealing to suffering and showing that suffering could be minimized by active euthanasia alone.

Allowing to die and actively killing, are the irrelevant grounds which Rachels thinks that CDE is based on. That allowing to die should be permitted whereas actively killing should be opposed. As said in the previous argument if a patient is dying and the process is painful, such suffering can be controlled by the application of doctrine of double effect. There is no such a need to recourse to active euthanasia.

Therefore, the suffering is not the relevant ground and its irrelevance is shown in the previous arguments. The relevant grounds are killing and terminating the extraordinary care. These are relevant in CDE and on this relevance the distinction between active euthanasia and terminating extraordinary medical care is based.

3.3.3. Criticism of that there is no Moral Difference between Doings and Refraining

Rachels claims that there is no moral difference between doings and refraining, therefore wherever refraining is allowed doing should be permitted too. From the claim, Rachels attempts to prove that wherever passive euthanasia is allowed active should be allowed too. And, therefore according to Rachels CDE is false. The logical form of the argument according to Don Berkich is as follows:

1. If killing is morally worse than letting die, then for any two cases C1 and C2, where C1 and C2 are exactly alike in all respects except that in C1 there is a killing while in C2 there is a letting die, C1 is morally worse than C2.

2. It is not the case that for any two cases C1 and C2, where C1 and C2 are exactly alike in all respects except that in C1 there is a killing while in C2 there is a letting die, C1 is morally worse than C2.

Therefore

3. It is not the case that killing is morally worse (1&2)

4. If CDE is true then killing is morally worse than letting die.

Therefore

5. CDE is not true. (3& 4). (Berkich , 2003)

In other words, the argument argues that CDE is false by showing that passive euthanasia is morally no better than active euthanasia or, equivalently, that active euthanasia is morally no worse than passive euthanasia.

The researcher's position is that Rachels's argument is invalid due to four reasons: (1) irrelevance to AMA's statement; (2) differences between the cases because of intentionality, causality, and agency; (3) straw man fallacy, (4) and weak analogy.

The first reason is that the argument is irrelevant to AMA's statement which does not make any distinction between killing and letting die. The AMA's statement prohibits the intentional killing and allows the termination of extraordinary medical

treatment. Rachels's argument against the statement is irrelevant because the statement is not about letting die as elaborated in the conceptual framework of this chapter.

The second reason is that even if Rachels thinks that withholding extraordinary treatment is letting die, nevertheless, his argument still fails because in active euthanasia killing is intended whereas death in passive euthanasia happens naturally without any intention. The crucial differences between active and passive euthanasia which make them different are: intentionality, causality, and agency and these three concepts make a moral difference. Therefore, the premise (1) in the above argument is invalid. C1 and C2 are not alike; therefore they are not alike morally. It should be noted here that Rachels is making argument against AMA's statement.

The first argument in favor of above claim is that the intention in both cases is different therefore the cases are different morally. The difference of intention is well understood by Rachels; that is why he has disregarded such difference. Moreover, Rachels is a utilitarian consequentist, therefore intentions are not considered by him, and only consequences are relevant to his ethical theory. Rachels suggests that bad intentions and good intentions are relevant to bad and good characters and they have no connection with moral actions as such. However, Rachels's disregard of intentions is not sufficient to remove the importance of intentions from the subject of delivering any position on any ethical action. The researcher thinks that relevance of intentions is of importance the morality of actions; furthermore, the researcher suggests the view that killing and letting die are not just morally different due to intentions alone,

but due to other factors which are morally relevant such as causation and agency.

Rachels's immediate respondent, Thomas Sullivan, pointed out the problem of intentionality in Rachels's thought and he suggested that Rachels makes the distinction between the act of killing and the act of letting die be "a distinction that puts a moral premium on overt behavior — moving or not moving one's parts — while totally ignoring the intentions of the agent" (Sullivan, 1977/ 1994a, p. 135). The fact is that an intentional action or omission is different in character, both morally and legally, from an unintended consequence. Our intentional actions say something about us and our character that no unintended side-effect possibly can. Unlike unintended consequences, our intentional conduct is always within our control. An intentional act is one of choice. An intended act "remains, persists, ... [and] is synthesized into one's will, one's practical orientation and stance in the world (Finnis , 1990). As Charles Fried has put the point:

[I]t is natural that the most stringent moral judgments should relate to intentional acts.... Morality is about the good and the right way of our being in the world as human beings. And the way we relate to the world as human beings is as we pursue our purposes in the world, i.e., as we act intentionally.... This primacy of intention explains why in law and morals a sharp line is drawn between the result, which is intended [,] ... and the certain concomitant, which [is not] intended.... To see a paradox in this distinction assumes that because the result in the world is the same in the two cases the

judgment in them must be too. In short, it ignores the element of purpose.

(Fried, 1976)

To return to practical nature of euthanasia, the main difference between active and passive euthanasia is because the intention in both cases is different. In passive euthanasia, the patients and doctors who resort to withdrawing or terminating medical care do so not for the reasons of intending the death of the patient. Moreover, the Patients who decline the extraordinary medical care do so for many reasons that in no way implicate an intention to die. They may wish to avoid further pain associated with the invasive treatments and tubes and the poking and prodding of modern medical care. They may wish to avoid the sense of indignity that dependence on medical machinery sometimes can bring. They may wish simply to go home from the hospital, to be with loved ones, and to restore their privacy. None of these decisions--or any of the other countless reasons for refusing care expressed every day by persons confronting an inevitable death--involves intent to die even when death is foreseen. Likewise, those persons who assist patients in declining unwanted treatment need not necessarily intend death as either a means or as an end. They may intend only to discontinue treatment to permit the patient to go home, to live without intrusive assistance, to avoid further pain associated with treatment. They may foresee death as a result of their actions without ever purposefully seeking it out. As the AMA (1992) has put the point, the "withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and non malfeasance," while assisted suicide is "contrary to the prohibition against [intentionally] using the tools of medicine to cause a patient's death (pp. 2230-33).

The second argument which supports the above claim is that causation and agency make the cases of active and passive euthanasia morally different. Philippa Foot has argued very well on the issue. Her argument makes a distinction between active and passive euthanasia by stating that “a death comes about through our agency if we send someone poisoned food or cut him up for spare parts, but not (ordinarily) if we fail to save him when he is threatened by accident or disease” (Foot, 1984 /1994b, p.282). She furthermore states that “the difference between act and omission is in fact irrelevant to any moral issue except in so far as it corresponds to the distinction between allowing something to happen and being the agent to whom the happening can be ascribed (Foot, 1984 /1994b, p.281). She therefore challenges the utilitarians, who place the whole moral significance of an action in its production of good or harm, that they must treat the difference between initiating and allowing as having no independent influence on morality. Philippa Foot's suggestion is that in active euthanasia the physician is cause and agent who performs the action of killing, whereas in passive euthanasia the physician is neither cause nor agent to killing or letting die a patient.

The third argument is that Rachels's claim unreasonably disregards the distinction between *ignorance of law* and *ignorance of fact*. The distinction is widely held decisive in every criminal or civil law texts and accordingly acted upon by courts. Rachels uses ignorance of fact in his legalization proposal, therefore, the researcher believes that the mention of ignorance of fact does not stand outside the context. The ignorance of fact, if understood properly is that it speaks about the intentionality, motive, and purpose. The law reflects the distinct moral force of intention that we

understand through our common experience. A crime committed intentionally receives greater punishment than the same act done unintentionally. We recognize differing "degrees" of homicide, and countless other crimes, depending upon whether the act was done intentionally, knowingly, recklessly, or negligently. Such differentiation continues through sentencing. Thus, the law treats the driver who speeds recklessly but harms the darting child accidentally differently than the depraved killer who deliberately plans to harm the child. However, Rachels may object to this analysis that his position is moral and not legal. The response to such claim is that though it is a fact that a legal action does not need to be a moral one and vice versa, but the context in which Rachels states his position is a legal one. His normative decisions are addressed to physicians and courts alike. And his proposal on legalizing active euthanasia is also of legal nature. Therefore, Rachels's position is not in a shape to avoid its legal criticism and therefore the adverse ramifications of his position. Therefore, Rachels's removal of intention from judging an action morally or legally is not only against the positive legal procedures but also against his own legalization proposal where he states that a physician can defend his act of mercy killing, besides other grounds, on the basis of ignorance of fact.

The third reason is that Rachels makes very superficial and shallow claim that if a patient is dying and could be in fact cured and doctor leaves such a patient without care and such a patient dies, and in the case killing and letting die would make no difference. Rachels claims that in the same manner a physician lets a patient die. Therefore, active and passive euthanasia are the same. Rachels's claim is very irresponsible and subject to fallacies such as *straw man fallacy*, *missing the point*,

and equivocation; because terminating ordinary medical care when the patient is potentially able to recover is not the subject matter of active euthanasia or passive euthanasia. Of course, if a doctor lets a curable patient die by withholding, withdrawing or terminating medical care in such a case the physician's act would not be even an active euthanasia; his action will be a homicide, a crime. Rachels's by arguing from such a proposition diverts the debate and leads his argument to straw man fallacy; he therefore misses the point and leads to equivocation: passive euthanasia therefore becomes neither mercy killing, nor letting die but a murder.

From the above reasons, it is clear that the intention is crucial in making a moral and legal difference between two actions with similar consequences or unintended consequences. The same is true about the two hypothetical cases of Smith and Johns which Rachels gives in his argument. The cases are different, therefore active and passive euthanasia are different.

The fourth reason is that Rachels's illustration of Smith and Johns in support of his argument commits fallacy of weak analogy. Rachels hypothetical case as mentioned earlier is called "bare difference" argument of Rachels. The argument contrasts two cases of Smith and Jones. The contrast is an attempt to show that two different actions — one killing and other letting die — are morally the same. In fact, the cases are supposed to show as presented by Rachels that the difference between killing and letting die is irrelevant to any moral judgment. But the contrast fails to make the point. Both the cases show the same result, however, the contrast is not *analogous* with the actual case of euthanasia. The analysis of the case shows that in

both of these cases the victim is a person who is potentially able to live. In Smith's case the victim is deliberately murdered and in Jones' case the victim is intentionally left to die. Comparing the same case with euthanasia, in active euthanasia a person whose fate is not yet known whether he will live or die or at most he may be going to die, is being killed whereas in passive euthanasia such a person is left to die. Comparing case of Jones and passive euthanasia the analogy becomes problematic. In Jones' case the victim is a healthy young boy with a good potential for life, whereas in passive euthanasia the patient is terminally ill with no hope of recovery. In Jones' case if help is extended to the victim, he could be saved, whereas, in passive euthanasia even extending help would not make things better or rescue the dying person from process of death. Furthermore, Unlike Jones' cousin, the recipients of passive euthanasia are not victims; they are autonomous agents who have the right to refuse treatment. If a doctor administers treatment against the will of patient, he infringes on the rights of the patient as a free agent and is guilty of assault and battery. Thus in the case of passive euthanasia, the doctor is not allowed to help the patient and should not be held morally responsible for the death of the patient. Jones has a choice to save his cousin and does nothing while the doctor is unable to do anything to save his patient because of the patient's autonomy and right to refuse treatment. Thus even though there is , on Rachels's formulation, no moral distinction between killing and letting die there is a distinction between active and passive euthanasia. The two cases are not analogous and the distinction between active and passive euthanasia lies in the patient's autonomy and ability to refuse treatment. Therefore, the inference from killing and letting die to active and passive euthanasia does not

stand valid.

3.3.4. Criticism of that the Arguments in Favor of the Conventional View do not Work

Rachels mentions that one often heard argument for the conventional view goes like that in passive euthanasia, there is nothing that the doctor does which can be called “cause of death”. The disease causes the patient to die, not the doctor. So how can the doctor be held responsible for the death, if he doesn't even ‘do’ anything?

The logical form of the argument according to Don Berkich is as follows:

1. Active euthanasia is doing something to bring about death.
2. Passive euthanasia is not doing anything
3. Doing something to bring about death is worse than not doing anything.

Therefore

4. Active euthanasia is worse than passive euthanasia (1, 2&3)
5. If active euthanasia is worse than passive euthanasia, then CDE is true.

Therefore

6. CDE is true (4&5) . (Berkich , 2003)

Rachels responses to above argument and shows that the argument in favor of CDE is unsound. Rachels shows that premise 2 “Passive euthanasia is not doing anything” and premise 3 “Doing something to bring about death is worse than not doing anything” are false.

Passive euthanasia is not doing anything, as the premise 2 states in the argument. But Rachels maintains that letting a patient die is also doing. Rachels's argument is unsound due to two reasons: (1) the direct cause of death is different, in the active it is the doctor and in the passive it is the disease itself; (2) Rachels's argument is fallacious due to straw man fallacy.

The first reason is that the direct cause of death is different; in active euthanasia it is the doctor as a human agent who actually kills the patient, whereas in the passive euthanasia it is the disease itself. The distinction between active and passive euthanasia is clear that causality of the death in active euthanasia is a lethal injection whereas in passive euthanasia the cause of the death is disease itself. The distinction pivots on the way we understand causality and culpability. In killing, the cause of death is the lethal intervention. In allowing to die, the cause of death is the natural biological process. When the cause of death is the impersonal force of nature, no one can be held responsible. But if death results from the human action of injecting or ingesting lethal medication, then someone can be held culpable. The causality in killing and letting die cannot be the same; Daniel Callahan has put the difference succinctly as follows:

[I]t confuses reality and moral judgment to see an omitted action as having the same causal status as one that directly kills. A lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a healthy person. Turn off the machine on me, a healthy person, and nothing will happen. It will only, in contrast, bring the life of a

sick person to an end because of an underlying fatal disease. (Callahan, 1992, pp. 52-55)

The above case vividly shows that as far as the death of a patient is concerned it is in active euthanasia, that a doctor does something which kills the patient and in passive euthanasia the case is just not the same, therefore the premise 2 in the argument is valid. The premise 3 is per se valid that doing something is literally killing and killing is worse from not killing and it is even worse than letting die because of the reason shown in this research, mostly where it is shown that Rachels's argument that active euthanasia is more humane than passive euthanasia is criticized.

The second reason is that the misrepresentation of the case is evidently shown in this matter. The AMA's statement does not state about doing and not doing. It explains that not doing in case if the doctor foresees the death. But Rachels's rebuttal relates to the case when the patient is suffering the curable diseases (Rachels, 1975/1994a, p.118). Therefore, Rachels is committing straw man fallacy.

3.4. Criticism of Rachels's Arguments for Active Euthanasia

Rachels's arguments for active euthanasia are of types. The first type is based directly on his biological and biographical distinction as elaborated in the conceptual framework. The second type of arguments by which he supports active euthanasia are those which show that the distinction between active euthanasia and passive euthanasia is absurd morally. And wherever passive euthanasia is applicable, active should be permissible as well. This has been shown in the second part of this chapter. The first two types of arguments can be classified as indirect arguments. The third

type of arguments is Rachels's direct arguments as discussed in this part of the chapter. The ethical arguments for and against euthanasia have remained largely unchanged for centuries. These arguments can be organized under three themes: autonomy, killing vs. allowing dying, and beneficence" (Gula, 1999a, pp. 501-505). Rachels's arguments are not different from these arguments; however his way of presenting them is different.

Rachels believes that active euthanasia is morally justified in some instances and that at least two strong arguments support this position. The first is the argument from mercy; the second is the argument from the best interests and golden rule (Rachels, 1981/ 1994b, p.146). He adds one more argument for the legalization of active euthanasia based on the right to liberty (Rachels, 1983). Briefly, this argument states that dying people should be free to choose euthanasia as a matter of personal liberty.

The very crucial part of Rachels's argument for active euthanasia is that they are interconnected in a way that no single argument stands on its own to support his position. His first argument from mercy shows the problem of pure utilitarianism, to remove such a difficulty, he moves to best interest argument, where he feels helpless to support his best interest which he tries to support by the golden rule argument and the golden rule argument ultimately depends on autonomy. Autonomy becomes problematic and more problematic by his legalization proposal for active euthanasia.

Therefore, there are main three arguments as criticized in the following part of the chapter.

3.4.1. Criticism of the Argument from Mercy

Rachels's position is that it is cruel and inhumane to refuse the plea of a terminally ill person that his or her life may be ended to avoid unnecessary suffering and pain. Allowing such a person to terminate his or her life is an act of mercy. Rachels supports this argument by documenting various cases in which he describes the suffering of terminally ill patients and suggests that their suffering could be stopped by active euthanasia.

The above argument is similar to the first argument against CDE which shows that active euthanasia is more humane than passive euthanasia. The response to that argument is given in the respective place. The response, however, is not different from the response given to the former argument under "3.3.1. Criticism of That Often Active Euthanasia Seems More Humane Than Passive".

3.4.2. Criticism of the Best Interests and Golden Rule Argument

Rachels's argument from mercy is a utilitarian argument. Rachels is himself uncomfortable with the pure utilitarian argument, therefore he suggests the best interest and golden rule argument. He claims that the following argument is sound and proves that active euthanasia can be justified:

If an action promotes the best interests of everyone concerned, and violates no one's rights, then that action is morally acceptable.

In at least some cases, active euthanasia promotes the best interests of everyone concerned and violates no one's rights.

Therefore, in at least some cases active euthanasia is morally acceptable.

(Rachels, 1981/ 1994b, p.149-150)

Rachels supports the above argument with golden rule argument. Rachels relates the Golden Rule to active euthanasia by saying that if there are two choices to die: (1) to die quietly, and without pain, from a fatal injection; and (2) to die of an affliction so painful that for several days before death you would be reduced to howling like a dog, with your family standing by helplessly, trying to comfort you, but going through its own psychological hell. Rachels states that it is hard to believe that any sane person, when confronted by these possibilities, would choose to have a rule applied that would force upon him or her the second option. And if we would not want such a rule, which excludes euthanasia, applied to us, then we should not apply such a rule to others (Rachels, 1981/ 1994b, p.151-152).

There are three reasonable ways to argue against the Best Interests and Golden Rule Argument and therefore rendering them invalid. They are: (1) the argument is based on subjective moral judgment, failing the universalization test; (2) it may not be in my own best interests or in the best interests of others for me to die; and (3) the argument is based on indefensible autonomy.

Firstly, the best interest and golden rule arguments are based on subjective moral judgment, therefore the arguments fail the morally universalization test and become subject of partiality. The universalization test is crucial because Rachels himself accepts categorical imperative and therefore he is supposed to be having no

objection if his moral position is subjected to such a test. If a person takes anything in his own interest, it does not guarantee that such an act would be desirable to other people. Similarly, not everything people would wish to have done to them is morally appropriate. Put differently, people can dehumanize themselves — and actually do so in active euthanasia by intentionally killing themselves or by others intentionally killing them. The golden rule argument fails due to its partiality and it fails the test of generality. First of all if active euthanasia is accepted by its acceptance from some patients and that does not make it generally acceptable. The approval is very subjective in its nature. M. Cathleen Kaveny has suggestion also supports the above position as follows:

The most pressing challenge facing opponents of assisted suicide or voluntary euthanasia can be found in the faces of those who request such practices in order to put an end to their suffering. They are pointing to their own pain as a justification for carving out an exception to the general legal and moral rule against intentionally killing the innocent. (Kaveny, 1997)

The closely connected to the above position is that the justification which some terminally ill patients give for euthanasia need to be scrutinized. The researches suggest that such approval of euthanasia is based mostly on the opinions of patients whose decision power is clouded either by medication or depression. Hendin, Foley, & White (1998b) have referred to these researches which scientifically describe the psychological conditions of terminally ill patients. The diagnosis of depression is particularly important since like other suicidal individuals, patients who desire an

early death during a serious or terminal illness are usually suffering from a treatable depressive condition (Harvey et al. & Ezekiel et al.). Although pain and other factors, such as a lack of family support, may contribute to a patient's wish for death, depression is the most important factor. In fact, researchers have found depression to be the only factor that significantly predicts the wish for death (ibid.). Two-thirds of patients requesting assisted suicide are depressed (ibid.) about the same percentage as those who attempt or commit suicide unaided (Robins et al. & Barraclough et al.). Hopelessness, the aspect of depression that helps distinguish depressed patients who are suicidal from those who are not, has been shown to play a similar role in predicting suicidal ideation in patients who are terminally ill (Harvey et al.) (pp. 243-70) . In face of all these evidences, Rachels's case again fails the test of universalization which includes that the decision should be autonomous, but the researches show that the euthanasia willing patients are not rationally autonomous, they are either depressed or they are driven by other factors than reason.

Furthermore, it is important to elaborate on Kant's categorical imperative, which negates the conclusions of Rachels. For Kant, our rational wills are the source of our moral duty, and it is therefore a kind of practical contradiction to suppose that the same will can permissibly destroy itself. Given the distinctive worth of an autonomous rational will, suicide is an attack on the very source of moral authority. Consequently, disposing of oneself as a mere means to some discretionary end is debasing humanity in one's person (as cited in Cholbi, 2004). Kant argued that taking one's own life was inconsistent with the notion of autonomy, properly understood. Autonomy, in Kant's view, does not mean the freedom to do whatever one wants, but

instead depends on the knowing subjugation of one's desires and inclinations to one's rational understanding of universally valid moral rules. (as cited in the New York State Task Force on Life and the Law , 1994, chap.5)

Secondly, it may not be in my own best interests or in the best interests of others for me to die. If I am willing to allow others to perform active euthanasia on me and, by the Golden Rule argument, I'm willing to do so to them, I am mistaken in my perspective and leaving out morally relevant information. Rachels's point that once we are old what should be done to us could be objected by the similar questions. "As I lie dying, will I be offered humane care, will I be done in too soon by some expediency, or will I be subjected to terminal torture?"(Vaux, 1989, p.29). Do terminally ill patients really ask for euthanasia the research on the topic negates the affirmation.

A new study published in the November 15 Journal of the American Medical Association has found that most terminally ill patients would not choose physician-assisted suicide or euthanasia to end their lives. Interviews with 988 terminally ill adults and their primary caregivers revealed that around one in ten people seriously considered using physician-assisted suicide or euthanasia and that less than 6 percent had seriously discussed the possibility or taken steps to commit suicide. The researchers, led by Ezekiel J. Emanuel of the Department of Bioethics at the National Institutes of Health, also found that those who considered either option are affected by depression, feel unappreciated, and have significant

need for help with the basics of living. The study's authors warn that doctors who receive requests for physician-assisted suicide or euthanasia should not consider patients to be definite about their decisions. (Emanuel , 2000, p. 1267)

After presenting the above studies, it is contextually suitable to look into a cited case of active euthanasia where a patient asks for lethal injection. Kuhse (1994) reports the following case:

Mary F. was dying from a progressively debilitating disease. She had reached the stage where she was almost totally paralyzed and, periodically, needed a respirator to keep her alive. She was suffering considerable distress. Knowing that there was no hope and that things would get worse, Mary F. wanted to die. She asked her doctor to give her a lethal injection to end her life. After consultation with her family and members of the healthcare team, Dr H. administered the asked-for-lethal injection, and Mary F. died.(p. 295)

The case of Mary F. who was “totally paralyzed” and periodically “needed a respirator to keep her alive” shows that she was kept alive by artificial means and these artificial means of prolonging death could be desperate to the level that a patient can ask for active euthanasia. The problem is if such a person was not kept alive in the first place by artificial means such need and desperation would have not occurred.

The main problem with Rachels is that he does not write anywhere about the misuse of medical technology.

Thirdly, both best interest and golden rule arguments are based on autonomy. The related and separate argument from autonomy is repudiated in the next part of the chapter. The repudiation of the autonomy argument invalidates both best interest and golden rule argument.

3.4.3. Criticism of Rachels's Argument from Autonomy

Rachels's conception of biographical life entails that a human being is an autonomous being; therefore, if a person autonomously chooses to end his or her life then it is morally permissible. And that dying people should be free to choose euthanasia as a matter of personal liberty. Rachels also supports his position by the analogy to the law of suicide. The argument begins with the proposition that since it is not unlawful for a person to commit or attempt to commit suicide, the law, implicitly at least, recognizes the right of an individual to take his or her life. From this premise it is argued that if an individual does have the right to take his or her life, he or she should be able to seek the assistance of others in achieving this end (Rachels, 1983, p. 19). Likewise, Rachels's main arguments in favor of active euthanasia are basically and essentially based on the consent of the terminally ill patient, that the justification of such practice is based on the free will and autonomy of the patient and furthermore on the joint consent of the other parties involved. Therefore, the argument from autonomy in favor of voluntary active euthanasia stands as the foundation of Rachels's thesis which according to him is based on two strong

arguments, the golden rule and the best interest arguments. The autonomy argument, by and large, involves discussions on liberty, rights, self determination and conception of autonomy itself. Rachels in his works refers to all these concepts to gain more warranty for his argument.

The researcher's position is that argument from autonomy fails to claim the sufficient support to substantiate a pro-position for the approval of active euthanasia. The reasons which support such a position are: (1) invalidity of civil right's claim; (2) weak analogy between suicide and euthanasia; (3) unwarranted influence of patient's autonomy on doctor's autonomy; and (4) unattainable autonomy of the terminally ill patients.

3.4.3.1. Self-determination and Euthanasia

Among many grounds to claim that a person enjoys a right to euthanasia is from self- ownership and closely connected to this is similar claim from self-determination.

The self-ownership claim states that a person enjoys a right to euthanasia because a person owns his body and hence such a person is morally permitted to dispose his body as he wishes. The claim on Rachels's view is sound as long as such giving away does not infringe anyone's rights. The claim from its nature is one of those related to right of property and ownership. And the implication, from this view, is that our relationship to our bodies is like that of our relationship to other items over which we enjoy property rights. Therefore, we can dispose our bodies as we dispose other owned things and objects. As a result, since property rights are exclusive

therefore others may not interfere with our efforts to end our lives. The concept of self-ownership whether related to euthanasia or suicide is one of the famous arguments. However, the very important factor is that the analogy between property-ownership and self-ownership is that we cannot own ourselves the way we own things which belong to us. There are two very important points which should be considered; one is that we own things because they are metaphysically distinct from us, whereas our bodies are not so. Even under all dualistic views of human nature, our selves are not sufficiently distinct from our bodies to implicate any ownership. Rachels's distinction of biological and biographical life is also one of such views; his biographical life is necessarily connected to and dependent on biological life. Indeed, the fact that certain ways of treating ordinary property are not available to us as ways of treating our bodies, we cannot give away or sell our bodies in any literal sense, suggests that self-ownership may be only a metaphor meant to capture a deeper moral relationship (Kluge, as cited in Chobli, 2004, *Libertarian Views and the Right to Suicide*, para.4). The other point is that even if we accept the self-ownership claim, the claim from its implication will lead to extreme moral subjectivism. Acting out of subjective moral discretion, even if it does not harm any one, may be somehow acceptable in some case, however such case will not be sufficiently enough to make a moral claim and subsequently will lack in becoming a legal position.

The right of self-ownership is closely connected to the right of self-determination. It is a right to shape the circumstances of our lives so long as we do not harm or imperil others. However, relating right of self-determination to determining the circumstances of death is a different case. Because, it does not seem

to follow from having a right to life that a person has a right to death. The rights are of two kinds: *inalienable* and *alienable*. Inalienable rights are those that by their nature cannot be taken away, violated, or transferred from one person to another. They are considered more fundamental than alienable rights, such as rights in a specific piece of property. The right to life is inalienable, since in order for me to kill myself, I must first renounce my inalienable right to life, which I cannot do (Feinberg as cited in Chobli, 2004). John Locke has the similar views he states that in the State of Nature no one has the right to take their own life, or assist in the death of another individual (Locke, 2001, pp. 72-73).

Rachels's position on self-determination is however a confused one if a holistic view of his thought is taken. His claim for autonomy and self determination leads from two positions: biographical life and civil liberty.

From the point of biographical life it does not entail that a person who has lost his biographical status could claim any inalienable and alienable right. As the researcher has mentioned earlier while criticizing the biological and biographical distinction that the distinction is slippery and leads to involuntary and non-voluntary euthanasia. However, from the same perspective Moreland's (1990) following conclusion briefly shows the conceptual complications in Rachels:

According to Rachels, the rule not to kill is no longer morally relevant to people without biographical lives. This is because the point of the rule is to protect people with biographical lives. It would seem, then, that a person who no longer has such a life -- who has no point of view -- is no longer included in

our duty not to kill. But if the person has lost the right not to be killed, it would seem that other rights would be lost as well, since the right to life is basic to other rights. In this case, it would be morally permissible to experiment on such a person or kill him or her brutally. Why? Because we are no longer dealing with an object that has the relevant rights. (p. 74)

From the above analysis, it seems that Rachels's biographical life and autonomy are in conceptual tension to lead to any clear position because of conceptual and theoretical complications. Nevertheless, Rachels's claim from civil liberty is a clear stand on the issue. However, it is practically and theoretically impossible to include euthanasia in civil liberties; on the contrary, euthanasia by its nature can only claim to be included in rights; and claiming euthanasia on the basis of rights is indefensible.

3.4.3.2. Analogy of Euthanasia with Suicide

Rachels attempts to defend his claim for active euthanasia by making the suicide and euthanasia equal. He therefore makes an analogy between suicide and euthanasia. When in fact, Rachels's analogy is weak and problematic. A crucial question which needs to be addressed is what significance, if any, should be attached to the fact that active voluntary euthanasia involves the direct assistance of a second party. It could be argued that an important distinction exists between suicide on the one hand, which is an autonomous and self-regarding act, and assisted suicide or active voluntary euthanasia on the other, which requires the involvement and assistance of a second party (Callahan, 1989, pp. 4- 5) . This second party involvement constitutes a crucial difference because the conduct changes from being

a purely private act to a form of public action with ramifications extending beyond the parties involved. Moreover, it could be argued as well that if the argument for active voluntary euthanasia is based on dignity of human freedom and self-determination, then it is inconsistent to ask someone else to assist (Linacre Centre Working Party, 1982, pp. 28-9).

3.4.3.3. Right, Liberty and Euthanasia

To return to the principle of self-determination, if one accepts the principle as the basis for active voluntary euthanasia, it remains to be determined what legal status should be given to such a right; should that be a basic human right or a legal right. The recognition of the right to die as a human right would create duties on the part of the state; it would not confer on individuals any legally enforceable right to active voluntary euthanasia or impose any obligation on doctors to participate in its administration. In light of this, it seems practically impossible for euthanasia to happen, because euthanasia involves physicians who under such right cannot be forced to involve with euthanasia practice.

The situation is more problematic where the right to die is expressed in terms of a legally enforceable right. Apart from problems of definition, there are potential difficulties in adopting a strict rights-based model as the basis for legalization of active voluntary euthanasia. Although the notion of 'rights' is expansive and, in its wider sense, can be used to encompass a variety of legal concepts, (Hohfeld, 1919, pp. 6-7, 36-8) strictly speaking, rights, as distinct from liberties or privileges are correlative with duties. Thus, the creation of any right to active euthanasia tends to

imply a corresponding duty on the part of someone to become actively involved in bringing about death. Whereas, according to accepted principles of autonomy and liberty, individuals should be free to pursue their own life choices, provided that this does not violate the rights of any other parties. In promoting the self-determination and autonomy of the patient, there appears the responsibility not to interfere with the autonomy of others. In particular, doctors should not be required to abdicate their autonomy in favor of that of the patient. The position of other parties, and their right to remain free of involvement in the practice of active euthanasia poses a general problem in any attempt of approving right to euthanasia as a claim right. Certainly in the US constitutional context, the courts have already indicated that the recognition of a constitutional right to physician assisted suicide does not entail any duty on the part of any doctor (*Compassion in Dying v. State of Washington*, 1996).

Another possibility is for the right to active voluntary euthanasia to be framed simply in terms of a right of one person to authorize another to kill him or her intentionally and directly but without creating a right to demand such assistance. There is broad agreement amongst euthanasia advocates that it would be inappropriate to impose a duty on any person to take the life of another. Although such a duty would uphold the autonomy of the patient who requests assistance, it is recognized that it would be an unjustifiable interference with the autonomy of others. It is primarily to avoid the implication of any such duty and the resulting infringement of the autonomy of other parties that a strictly rights-based model has been widely rejected as an appropriate basis for the legalization of active voluntary euthanasia (Trowell, 1973, pp. 116-21). Therefore, argument from autonomy involves rights and

duties , and a terminally ill patient's autonomy cannot be realized unless autonomy of other parties are endangered, and doing so is not possible by any rights based model for euthanasia.

3.4.3.4. Autonomy of Patients

The further objection to the argument based on autonomy is about autonomy itself and that is the consent of the patient on termination of life actively. The concerns involved are various such as how can it be sure that the person in condition which requires active euthanasia could have a free will; "there could be concern that the use of a pain killer in a dying individual could so cloud his conscious response that he might not in his dying moments be in a position to make decisions" (Koop , 1989a, p.73). The consent therefore received could not be accepted as reasonable and sound to substantiate such a decision.

To support the above concern on practical grounds, the researches show that most of the patients who wish for death are depressed persons. The patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. Although pain and other factors, such as a lack of family support, may contribute to a patient's wish for death, depression is the most important factor. In fact, researchers have found depression to be the only factor that significantly predicts the wish for death. Researches show that two-thirds of patients requesting assisted suicide are depressed about the same percentage as those who attempt or commit suicide unaided. Hopelessness, the aspect of depression that helps distinguish depressed patients who are suicidal from those who are not, has been

shown to play a similar role in predicting suicidal ideation in patients who are terminally ill (Hendin, Foley, & White, 1998, p. 243-70) . Paul R. McHugh argues, but when it comes to terminally ill patients, "outside forces" are likely to "overwhelm the self, rendering it vulnerable to unreflective impulses" (McHugh, 1999, p. 5-6). Due to these factors, realization of patient's true autonomy becomes unattainable. Aristotle rightly points out the difficulty of making a rational decision while in the grip of pain and suffering. He describes the case of physicians that though they are experts on matters of life and death; they even ask other physicians to treat them when they fall sick. Aristotle states:

Doctors themselves call in others doctors to treat them when they are sick, and trainers call in other trainers when they are exercising, their assumption being that they are unable to judge truly because they are judging about their own cases, and while in pain. (Aristotle, 2000, iii 16.1287a41 – b3)

Besides above grounds, Rachels's argument for active euthanasia is unnecessary. There is practically no such a need to resort to active euthanasia if medical technology is not allowed to mishandle the patients and prolong their dying process. On the other hand if a person is being kept alive by artificial and extraordinary means, in such a case the treatment can be withdrawn. And in cases of patients whose life is painful, their problem can be successfully resolved by the pain medication and wider use of principle of double effect. Therefore, as such, active euthanasia is indefensible because of serious inadequacy of autonomy argument.

3.5.Criticism of Rachels's Proposal of Legalizing Active Euthanasia

Rachels while using the fundamental procedure in the criminal trials in American courts proposes a legal scenario in which there is legally a successful possibility of making active voluntary euthanasia a reality without any adverse repercussions to the physician who performs such an act. He elaborates that under his proposal, “someone charged with murder could also plead mercy killing; and then if it could be proven that the victim while competent requested death, and that the victim was suffering from a painful terminal illness, the person pleading mercy killing would also be acquitted” (Rachels, 2003). Rachels while explaining the above procedure mentions that under the above proposal no one would be "authorized" to decide when a patient should be killed. He adds that “there are no committees to be established within which people may cast private votes for which they are not really accountable; people who choose to mercy kill bear full legal responsibility, as individuals, for their actions” (Rachels, 2003). Rachels further explains that by following the proposal “we would rely on the good sense of judges and juries to separate the cases of justifiable euthanasia from the cases of unjustifiable murder, just as we already rely on them to separate the cases of self-defense and insanity and coercion” (Rachels, 2003).

Rachels's proposal of legalizing active euthanasia is problematic and unpersuasive. After analyzing his proposal from the legal and practical points, his proposal turns out to be impractical. The main problems in the proposal are enumerated as follows:

(1). The proposal fails to provide clear guidelines. The proposal has very ambiguous guidelines for both doctors and courts. For example, Rachels recommends doctors to recourse to ignorance of fact and recommends judges that doctors who have committed mercy killing could be acquitted on basis as judges consider in criminal trials such as grounds of insanity. This ambiguity renders the proposal unclear, therefore not worthy of adaptation.

(2). The proposal suggests that the mercy killing act would be a murder and could deserve a trial where a doctor can defend his action. This is practically very difficult, but impossible. The impossibility specially arises when the murdered person is killed and there is no one left to follow his killing or those who follow have vested interests.

(3). Rachels is very naive about homicide and criminal law procedures. He suggests that when there will be no one to follow the murder case as guardians will give consent positively, the doctor will not be bothered by any court trial. Rachels ignores the role of the state and police. Rachels confuses criminal trial with civil trial.

(4). The other problem is if such proposal accepted who would be ready to face the trial and jury after every act of mercy killing. Would not such a doctor be scared who could expect anything from jury in absence of any guidelines and legalized procedures. There will not be many doctors available on earth who would be ready to go for murder trial after every euthanasia, and such a way will easily open way for corruption of the physicians who are historically thought to

be humane.

(5). The biggest problem which the proposal fails to deal with is that on one hand Rachels dismisses any committees which could decide the euthanasia, whereas on the other hand he leaves the matter unto doctors that they could defend themselves on commonsense or ignorance of fact, which gives an easy hand to a doctor to kill people without any requirements.

3.6. Modern Advanced Medical Technology and Euthanasia

This research used broad construal definition of euthanasia for the sake of convention and criticism, however the researcher agrees only on the narrow construal definition of euthanasia which includes only active euthanasia as euthanasia. And active euthanasia should be prohibited. To support such a position, the researcher starts with the propositions: (1) that among moral hazards of advanced medical technology is that it allows prolonging of death; (2) the cases of passive euthanasia are the cases of the natural state of extinction and thought to be passive euthanasia due to inappropriate use of advanced medical technology; and (3) the need of active euthanasia as defended by Rachels due to some case studies of patients is also undefendable due to two reasons: (I) that the cases are actually mishandled by doctors due to misuse of medical technology by prolonging life of dying patients and (II) if there are terminally ill patients in anticipation of death and living in painful state, such patients could be given pain killers to get their pain under control even though such medication shortens their life due to the side affects of such medication.

Therefore, Rachels's interpretation of active euthanasia as killing and passive euthanasia as letting die is a false dichotomy.

In the following part of the chapter, the researcher will elaborate on the above propositions respectively.

3.6.1. Moral Hazards of Modern Advanced Medical Technology

The most crucial and serious part related to euthanasia is the role of modern advanced medical technology; and Rachels has almost left it untouched. He focuses on the problem of those suffering in some ailment and focuses on the solution of such cases. Whereas, the beginning and causes of problems remain untouched in Rachels's thought; he apparently has no suggestions on that part to medical and legal authorities. However, he has suggestions to both doctors and courts on the ways and methods of how terminally ill patients could be killed.

As a matter of fact, modernity and advance of science and technology, besides other goals, remain centered to one main issue and that is discovering natural causes, and devising technological tools and machines, which could allow imitation of natural processes and with higher ambition of bringing nature ultimately under control. On one hand the ambition has brought comfort and progress to humanity in various ways, and on the other hand the same science and technology has brought hazards and misfortune to humanity in various domains on variety of levels and degrees. The medical profession could be treated as the most beneficiary of the modern science, however the misplaced use of medical technology has also created many ethical problems and among such problems is the issue of euthanasia. Joseph Fletcher has

put the case succinctly: "Most of our major moral problems are posed by scientific discoveries and by the subsequent technical know-how we gain, in the control of life and health and death. Ethical questions jump out at us from every laboratory and clinic" (Fletcher, 1987/ 1989, p. 88).

The involvement of medical technology with death and issue of euthanasia particularly stems from two main facts. The first reason is that, whereas in the past most people died in their homes, the vast majority now dies in institutions governed by the medical profession. In the United States and likewise in other developed countries, during the twentieth century, death moved out of the home and into medical institutions. In 1983 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, a report about US stated that: As medicine has been able to do more for dying patients, their care has increasingly been delivered in institutional settings. By 1949 institutions were the sites of 50 per cent of all deaths; by 1958 the figure was 61 per cent; and by 1977 over 70 per cent. Perhaps 80 per cent of the deaths in the United States now occur in hospitals and long-term care institutions, such as nursing homes (1983, p 17). The same trend is being reported in other countries, briefly, the developed countries top the list. (Bryant, 2003, p.205). Sharon R. Kaufman comments that "Today, more Americans die in hospitals than anywhere else, and the most frequent response to critical illness there is to try to stave off death with the most sophisticated technological means available. Approximately one-quarter of all hospitalized patients are treated in intensive care or cardiac care units before they die"(Kaufman, 2005, pp.1-8). Likewise, the other countries follow the same road; therefore death is now

very much a medical business. The other reason is that the fact that most people now die in hospitals has another side to it that modern hospitals usually provide high technology medicine with sophisticated resuscitation equipment and life sustaining machinery. The intensive care and employment of high technology complicates the process of dying and in fact prolong the process of dying in an unnatural way. Accordingly, Max J. Charlesworth (1989) has depicted the scene as follows:

In a sense the high technology hospital creates its own special ethical problems simply because it has the technology to artificially sustain and prolong the lives of gravely disabled newborns and others. The Karen Ann Quinlan case was a product of such a hospital situation in that since the life-sustaining technology was at hand it had to be used. Had Karen Ann been sent to a remote country hospital, nature would have quickly taken its course and she would have died. What is 'ordinary' run-of-the-mill treatment in a large high technology hospital is of ten quite 'extraordinary' beyond-the call-of-duty treatment in a smaller country hospital. In hospitals with sophisticated medical technology physicians would be culpably negligent if the complex medical technology were not used. As a result the tendency in such hospitals is to sustain people's lives just because the technology is available. (pp. 64-65)

As a result, the use of high technology has given the sense to humans that they are no more helpless onlookers in the presence of death; they are now “increasingly able to intervene in the process, using technological resources to direct or delay the

inevitable" (Veatch, 1989, p. 2) . Furthermore, the "human medical interventions have interrupted the natural death process to such an extent that very few illnesses can be said to have a natural course" (Omar, 1993, p. 613). These interventions have lead to prolongation of death and suffering. With this in mind, Omar Mendez states: "Sometimes, because of legal issues, we are driven to the point of doing the inhumane by... artificially maintaining a body that has no cognitive functions despite the family's requests and even the previously expressed wishes of the patient" (Omar, 1993, p. 614).

The abovementioned well documented scenario which takes place in medical setting encourages that a dying person should be first of all hospitalized, secondly such a person should be kept under high intensive care laid on life sustaining machines, and thirdly such a person should not be given chance to natural way of passing away. These reasons stand at the root of the problem of euthanasia; and they are totally ignored by Rachels. Rachels has nothing to say about it. This medical situation which is actually a set of unnatural settings has made the case of terminally ill persons so overwhelming on every front that has made Rachels and his proponents surrender before its inevitable demand of killing of mishandled and medically over-treated patients. The unfortunate picture of these patients which emerges because of the given reasons, is on an emotional level being the main drive behind the euthanasia movement and rationalization of mercy killing; the picture, being artificial and mess, provides arguments which are misguiding and compelling to mobilize support for active euthanasia. In other words, this intellectual helplessness in face of the circumstances is a vivid description in what Van Den Haag acknowledges:

More and more people reach advanced age. But for many, disability makes life a burden. Yet even when life is no longer desired, or consciously experienced, medicine can now prolong it. Although still fallible, diagnoses have become far more reliable than in the past; prognosis is fairly certain. Miracles--medical or religious--are rare. It is reasonable, then, to allow physicians to actively help end life when the patient so desires.... We should no longer ask whether assisted suicide, or mercy killing, should be allowed, but rather under what conditions. (Carr, 1995, pp. 50-51)

Alongside, the abovementioned surrender of intellectuals to the circumstances, the desperation of terminally ill patients who are kept alive against their wishes, had they were not kept artificially alive, they would have died, is not less at all. The desperation could be understood by the deaths of Rev. Henry Van Dusen and his wife, Elizabeth. Several years ago, the Rev. Henry Van Dusen and his wife, Elizabeth, both of them in pain and with no prospect of recovery, joined in a suicide pact. The deaths were front-page news in The New York Times and most other newspapers because Van Dusen was president of Union Theological Seminary and one of the most respected theologians in the world. In a suicide note, Elizabeth Van Dusen wrote: "There are too many helpless old people who, without modern medicine, would have died, and we feel God would have allowed them to die when their time had come" (Carr, 1995, pp. 50-51).

As indicated above, the terminally ill patients whose death is unnecessarily prolonged are unfortunate cases of mishandlement of advanced medical technology. The terminally ill patients whose recovery is not possible would have rather died naturally, had they not artificially kept alive. Furthermore, it is evident that a need for active euthanasia stems from the misuse of medical technology itself. The question arises about those terminally ill patients whose recovery is unattainable and there is no cure for them; are such patients suitable subjects for euthanasia, whether active or passive; the researcher's answer is of denial. Because, they are not subject to either 'killing', active euthanasia, or "letting die", passive euthanasia. Because, passive euthanasia is not letting die therefore it is not euthanasia.

3.6.2. Passive Euthanasia is not Euthanasia / Letting Die

The passive euthanasia, on Rachels's formulation, is defined as terminating or withholding or withdrawing the treatment and which eventually leads to the death of a person. The definition can be confusing that if ordinary medical treatment which can benefit a patient is withdrawn, withheld or terminated, to researchers understanding that kind of action is also active euthanasia. Rachels has also misunderstood passive euthanasia in these terms; according to Rachels, passive euthanasia means "letting die". The statement of AMA is somehow very careful understanding of the case, it states explicitly killing of patient is prohibited and such formulation can be easily classified as active euthanasia and on the other side it states that extraordinary treatment can be terminated if such treatment is not helpful. The case therefore if treated as passive euthanasia deserves a careful definition: that

passive euthanasia is withholding, withdrawing or terminating medical treatment from those patients to whom such treatment is useless or extraordinary. On this understanding the passive euthanasia is not euthanasia it is just that the death works its way. As an illustration, Daniel Callahan (1992) gives the following interesting comment:

[I]t confuses reality and moral judgment to see an omitted action as having the same causal status as one that directly kills. A lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a healthy person. Turn off the machine on me, a healthy person, and nothing will happen. It will only, in contrast, bring the life of a sick person to an end because of an underlying fatal disease. (Pp.52-55)

Therefore, the researcher maintains that passive euthanasia as widely known as letting die is misrepresentation of the actual scenario in which a patient takes course to his final exit without prolonging the process of his dying by using life sustaining high technology and unaffordable burdens of medical care and artificial means of maintaining biological processes. "Similarly, when a patient's condition is such that it is not reasonable to hope that any medical procedures or treatments will save his life, a failure to implement the procedures or treatments is not euthanasia. If the person dies, this will be as a result of his injuries or disease and not because of his failure to receive treatment" (Gay-Williams, 1979/1989, pp.97-98).

The real and actual case of euthanasia is only active euthanasia. Active euthanasia is killing a terminally ill patient to put end to his suffering. The point is

that is there really a need for such action on the part of a doctor, the simple understanding of the case is negative. The negation of such a need is backed by reasons: (1) a terminally ill person whose dying process is prolonged by life sustaining medical technology and extraordinary means is most of the time thought to be subject of active euthanasia, to avoid involvement of euthanasia such a person should not be kept alive by life sustaining and extraordinary means against his wish , if the suggestion is followed there will not arise any need of actively killing such a person and death will happen naturally due to illness, therefore active euthanasia will be avoided. The cases which are most of the time illustrated to be subject of active euthanasia are the cases actually mishandled by medical technology (2) the other reason is that even if extraordinary medical treatment is terminated and life sustaining equipments are disconnected , there is possibility of pain and suffering therefore active euthanasia can put end to such a pain, however the case is not so that only option of active euthanasia can put end to the problem, such person's suffering and pain can be controlled by medicine and palliative care , the medication besides soothing the pain may shorten life as a side effect, but such side effects are not intended they are by-products , therefore the option of active euthanasia can be avoided.

In short, if passive euthanasia means letting die , then there is no difference between killing and letting die: because if a curable patient is not treated medically such negligence is not different from killing. On the contrary, if passive euthanasia means discontinuing useless and extraordinary medical care from an incurable patient such termination of medical care is neither killing nor letting die. Therefore, on this

formulation passive euthanasia is not euthanasia. The question arises then who are the subjects of active euthanasia; the researcher response is that none but those whose death is prolonged, those who would have died naturally if not mishandled by extraordinary, useless, and futile medical technology.

3.6.3. Active Euthanasia is Mishandling of those whose Death is Prolonged

The need for active euthanasia, if there is any need, which the researcher thinks that there is not, is actually a consequence of man's mishandling the natural laws within the medical sciences. The actual natural law of medicine is that 'the living ought never to be treated as if they were dying, nor the dying as if they were living' (Vaux, 1988/ 1989, p.32). The law has been adversely affected by the misuse of advanced medical technology. The crucial shortcoming in Rachels's thought is that he tries to find the solution for mishandled patients to stop their suffering, but, deliberately, ignores the causes of such suffering. He has no suggestions to doctors not to modify nature and he has not made any criticism against that and on that base he argues that death should be also made in an unnatural way. The problem as such creates a dilemma for more nature loving people that how could they allow doctors to modify nature and then plead for nature to run as unhindered. The proper way is that to get it right in the beginning and it will be right in the end. And if we get it wrong in the beginning then we have to commit another wrong in the end to make it look better, we cannot get it right in the end when the whole matter is based on a wrong and mistaken foundation. The mishandling of patients by employing advanced medical technology is succinctly shown by Kenneth L. Vaux (1988/ 1989) as follows:

In recent years the qualities that morally distinguished the living from the dying have been blurred. With our life-prolonging techniques and medications, we have transformed death; we have taken it out of the acute, natural, and non interventional mode and made it more into a chronic, contrived, and manipulated phenomenon. Deaths as inevitable as Debbie's have been protracted by a range of interventions, including chemotherapy (disrupting the cellular-pathogenic process), analgesia (altering the release of natural body endorphins and narcotics), the administration of intravenous fluids and nutrients, and hospitalization itself. Logically and emotionally, we cannot intervene at one phase and then be inactive at another, more painful phase. We cannot modify nature and then plead that nature must be allowed to run its unhindered course. (p.32)

As indicated above, the need for active euthanasia is the one artificial. The doctors at one phase start prolonging death and at the point when the prolongation becomes costly on all fronts such as suffering and financial expenses then disposal of the patient in an unnatural way becomes eminent.

The above problem which shows the role of advanced medical technology in worsening the condition of dying people, can be well illustrated by the most famous and well documented cases debated in the history of euthanasia: Karen Quinlan, Nancy Cruzan, and Terri Schiavo. The 21-year-old Karen Ann Quinlan collapsed at a party after swallowing alcohol and the tranquilizer Valium on 14 April 1975. Doctors saved her life, but she suffered brain damage and lapsed into a "persistent vegetative

state." She remained in a coma for almost 10 years in a New Jersey nursing home until her death in 1985 (Koop, 1976/ 1989b, pp. 33-42). Like Karen Ann Quinlan, Nancy Cruzan became a public figure after entering a persistent vegetative state. A 1983 auto accident left Cruzan permanently unconscious and without any higher brain function, she was kept alive only by a feeding tube and steady medical care. The Cruzans stopped feeding Nancy in December of 1990, and she died later the same month (Crigger, 1990, p. 38). On 25 February 1990, 26-year-old Terri Schiavo suffered severe brain damage when her heart stopped for five minutes. Schiavo spent the following years in rehabilitation centers and nursing homes but never regained higher brain function. In 1998 her husband, Michael Schiavo, filed a legal petition to have Schiavo's feeding tube removed, saying that his wife had told him before her medical crisis that she would not want to be artificially kept alive in such a situation. After long court battle, in March of 2005 Schiavo's feeding tube was removed, and after two weeks without food and water, Schiavo died of dehydration on 31 March 2005. (Schiavo Case, 2007, p. 43060). These cases vividly show that how the death of these people was prolonged for years and how they were kept alive by artificial means either in a coma or in a persistent vegetative state. The unfortunate situation of these terminally ill patients is very clearly stated by John J Paris (1997):

We have come to believe that the "miracles" of modern medicine are able not only to defeat disease but to conquer death. With the rise of technological medicine, lives that once were beyond rescue can now be saved. Sometimes, however, that success comes at too great a price: a life of suffering, pain and despair. Patients like Karen Ann Quinlan or Nancy

Cruzan may now lie trapped by a halfway technology, one that can ward off death but not restore health, in a situation worse than death itself--an endless prolongation of their dying. (pp. 11-14)

There was not such a need to use medical technology to prolong the process of death the mostly it happens "almost at the will of the physician" (Koop, 1976/ 1989a, p.72) and such persons could have died easily in a natural way than becoming the problematic. The biological and moral hazard which advanced medical technology has brought seems unresolved problem to many and the same thinking is behind those who favor active euthanasia. The reason which they give behind their stand point is that since misuse of medical technology has created the problem, therefore it is unavoidable to surrender to the consequences. The problem with this argument is that instead of correcting the use of medical technology these people while feeling helpless before the use of medical technology, favor the active euthanasia. Gerald A. Larue (1989) has drafted the following statement on the same lines. He says:

We acknowledge that techniques developed by modern medicine have been beneficial in improving the quality of life and increasing longevity, but they have sometimes been accompanied by harmful and dehumanizing effects. We are aware that many terminally ill persons have been kept alive against their will by advanced medical technologies, and that terminally ill patients have been denied assistance in dying. In attempting to terminate their suffering by ending their lives themselves or with the help of loved ones not trained in medicine, some patients have botched their suicides and brought

further suffering on themselves and those around them. We believe that the time is now for society to rise above the archaic prohibitions of the past and to recognize that terminally ill individuals have the right to choose the time, place, and manner of their own death. (p. 160)

As mentioned above, the Gerald A. Larue's statement, it is quite evident that those patients who are treated as the subjects of active euthanasia are actually those case who are medically mishandled. The problem which seems is that cases which deserve to be treated as cases which should be left on their own and intervened fruitlessly and instead of life, death is being prolonged and once the case becomes problematic the active euthanasia is being sought. The researcher thinks that instead of reasoning for active euthanasia, it would be far better to reason against the inappropriate use of medical technology. "If biomedical acts of life extension become acts of death prolongation, we may force some patients to outlive their deaths, and we may ultimately repudiate the primary life-saving and merciful ethic itself" (Vaux, 1988/1989, p.32).

In light of all the above details, the researcher thinks that AMA's statement on euthanasia is valid. The statement makes a distinction between intentionally killing and withholding extraordinary medical treatment. Moreover, the AMA's position implies that the patients should not be intentionally killed and extraordinary medical treatment can be withdrawn or withheld by the permission of the patient or the hopeless condition of the patient by the permission of his legal guardians. Furthermore, the above findings also lead to the conclusion that Rachels's

categorization of active and passive euthanasia into “killing” and “letting die” is a false dichotomy. Rachels gives two choices to terminally ill patients: either killing or letting die, and prefers killing to letting die. Whereas the researcher thinks that both of these choices killing and letting die are irrelevant. The researcher, in light of the above details, thinks that there is only one choice: (I) to stop prolongation of death by the excessive and misuse of advanced medical technology, (II) to allow termination of extraordinary medical care from terminally dying persons and, (III) to allow use of pain medication by following legitimate procedures.

CHAPTER FOUR

Conclusion

This research demonstrates that James Rachels's defense of active euthanasia is conceptually, theoretically, practically, and normatively unjustifiable. Rachels's position on euthanasia is widely known as libertarian approach in contrast to the traditional doctrine of euthanasia (TDE) or conventional doctrine of euthanasia (CDE). The American Medical Association's (AMA's) position is in favor of the traditional doctrine. The traditional doctrine makes a distinction between active and passive euthanasia and prohibits the first and allows the latter. Whereas, Rachels's approach debunks the distinction and treats passive euthanasia unnecessary and painful; and prefers the active euthanasia. Rachels attempts to support his position by three ways: (1) by developing a set of concepts, (2) by dissolving the distinction between active and passive euthanasia, and (3) by arguing for active euthanasia. Furthermore, he proposes a proposal on the legalization of active euthanasia.

In the outset of this research a clear understanding of euthanasia is sought by analyzing a bunch of various definitions of euthanasia. The study shows that there are two different usages of the term, euthanasia: narrow construal of euthanasia, which refers to mercy killing or active euthanasia; and broad construal of euthanasia, which refers to both active and passive euthanasia. Rachels adopts the broad construal of euthanasia, and includes suicide and assisted suicide within his definition. Rachels's definition is unacceptable, conceptually unjustifiable, and most confusing, because it violates all the demarcations between euthanasia, suicide, assisted suicide, and

physician assisted suicide. Contrary to Rachels, the researcher agrees only with the narrow construal of euthanasia, i.e. active euthanasia. The researcher's definition of euthanasia is: intentionally causing a terminally ill person's death by performing an action. The definition is based on the facts that: (1) the death is caused by an agent (human) instead of the subject (the patient), (2) the causing of death is intentional, (3) the death is caused either by the request of the subject or the state of being of the subject to make it different from a pure homicide (4) the death is caused by commission or action and (5) the subject is terminally ill. As a result, passive euthanasia is expunged from the definition because euthanasia means the intentional, mercy killing; and in passive euthanasia intentional killing is not part of the withholding or withdrawing the unnecessary and extraordinary medical treatment. Therefore, the researcher's definition includes only active euthanasia "mercy killing" as euthanasia. The definition excludes: suicide, assisted suicide, physician-assisted suicide and passive euthanasia. The reasons behind not considering passive euthanasia as euthanasia is due to: (1) the death is natural, and not artificial (2) the death is not caused by action of any agent. The suicide, assisted suicide, and physician assisted suicide are excluded due to: (1) the death is not caused by an agent other than the subject. The very integral factor of the notion of euthanasia is being killed by some agent (person) instead of the subject.

The historical sketch of euthanasia as detailed in this research shows that problem of euthanasia has a long history of philosophical discussion; however, most of the discussion revolves around the issue of suicide. The late twentieth century shows a divide between suicide and euthanasia. Both these subjects become separate along with their subject matter and arguments; although there is an unavoidable overlap between

them. The peculiarity of euthanasia is because of its relatedness to medical profession and legal issues. The issue of euthanasia in its essential relation is practically connected with medicine; it has brought the medical profession in question. The defenders of active euthanasia suggest to redefine the profession not only as life saving but also as life taking. Similarly, the issue has brought in debate the rights, duties, and autonomy of both terminally ill patients and physicians. Due to the crucial touch of euthanasia to medical profession the American Medical Association (AMA) announced its position on the issue of euthanasia. The AMA's statement prohibited the intentional termination of the life of one human being by another, "mercy killing" and allowed the cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent. Rachels's interpretation of the statement is that it supports passive euthanasia and opposes active euthanasia. Rachels understands by active euthanasia 'killing' and by passive euthanasia 'letting die'. Contrary to Rachels, the researcher disagrees on such categorization. The researcher thinks that the statement refers to narrow construal euthanasia. Because, the cessation of the extraordinary means of medical treatment does not amount to 'letting die'. Therefore, Rachels's interpretation is both conceptually and practically unjustifiable.

The chapter two of this research deals with Rachels's thought on euthanasia in a detailed form. The ideas are grouped in three categories: conceptual framework, arguments for absolution of the distinction between active and passive euthanasia, and arguments for active euthanasia including the proposal on legalization of active euthanasia, respectively. Rachels is a moral, utilitarian philosopher; while elaborating his thought on euthanasia, he refers directly and indirectly to his conceptual framework

which permeates all of his arguments. Rachels's conceptual framework deals with three distinctions: (1) biological and biographical life, (2) killing and letting die, and (3) ordinary and extraordinary medical treatment. Rachels attempts to show that there is morally no difference between active and passive euthanasia and where passive euthanasia is appropriate, active should be allowed too. He challenges CDE for several reasons: (1) active euthanasia is in many cases more humane than passive euthanasia, (2) the conventional doctrine leads to decisions concerning life and death on irrelevant grounds, (3) the doctrine rests on a distinction between killing and letting die that itself has no moral importance, and (4) the most common arguments in favor of the doctrine are invalid. Furthermore, Rachels explicitly supports active euthanasia. Rachels states three main arguments: (1) the argument from mercy; (2) the argument from the best interest and the golden rule; and (3) the argument from autonomy. And finally, he proposes a "modest proposal" for the legalization of active euthanasia.

The criticism of Rachels's thought on euthanasia is the subject of chapter three. The research analyzes Rachels's thought in accordance and order of the preceding chapter. The chapter in argumentative and critical ways shows how Rachels's claims are unjustifiable on all fronts: conceptual, theoretical, practical, and normatical.

The researcher criticizes the conceptual framework which comprises of distinctions, and demonstrates that it has various problems which are reasonably not enough to support the soundness of Rachels's position and that of arguments which mainly draw on such distinctions.

Rachels's first distinction, biological and biographical life, holds that biological life is ethically unimportant, whereas biographical life is important and relevant. Rachels's support for active euthanasia is largely based on the distinction. The research shows that the distinction does not provide a valid foundation or criteria for the permissibility of active euthanasia. The distinction is rather inadequate due to: (1) reductive fallacy "oversimplification"; (2) slippery slope and (3) inconsistency with the main arguments of Rachels. The distinction commits reductive fallacy, because it reduces human person to some functions and therefore divides a human entity into a human being or biological life and human person or biographical life. The research shows that such distinction is possible conceptually and not physically. The distinction is both conceptually and practically unjustifiable: conceptually because it implies that besides terminally ill patients, many persons like mentally ill and retarded, drug and alcohol addicts, patients with Parkinson's and Alzheimer's diseases, and the comatose are not persons; and practically because the distinction entails the consequences which hardly seem to escape being the easy target of slippery slope; it leads to permissibility of not only voluntary active euthanasia, but non-voluntary and involuntary as well, because if having just a "biological life" without "biographical life" is a valid criterion for euthanasia then the consent of terminally ill becomes irrelevant. Therefore, the distinction defines a human person in way which is not coherent with the main arguments of Rachels such as best interest and golden rule argument and argument from autonomy, which are based on patient's consent and autonomy. Therefore, the distinction becomes irrelevant to Rachels's main arguments for active euthanasia. Nevertheless, the distinction if restricted to painful and suffering terminally ill patients

who are kept alive by artificial means makes some sense, however, in such a case killing actively is not the only option, the extraordinary treatment can be terminated. Therefore, such a distinction deserves to be shunned in face of its inadequacy.

Rachels's second distinction, killing and letting die, maintains that there is morally no distinction between killing someone and letting someone die. Rachels's 'killing' means active euthanasia and 'letting die' passive euthanasia; therefore active and passive dichotomy is a distinction without difference. The distinction pervades his arguments from mercy and bare difference. Rachels illustrates his point by a hypothetical example of Smith and Johns; Smith kills his cousin and Johns watches his cousin die without extending any affirmative assistance. The research shows that the distinction is: (1) irrelevant, (2) extraneous to the medical profession, and methodologically degressive. The irrelevance of the distinction to euthanasia is that it is not the case that doctors let the patient. The AMA's statement actually holds that if the medical treatment seems extraordinary and unbeneficial, in such a case the patient has choice to refuse the treatment. The future of such a patient remains to be seen in the future, and the possibility of patient's recovery is a matter of probability. Therefore, the distinction is theoretically unjustifiable. Furthermore, the distinction extraneous to the medical profession because omissions of ordinary care are as punishable as affirmative misdeeds in a patient physician relationship. The distinction may be somehow defensible in outside care taking professions where affirmative assistance may not be required; however a physician's omission of readily available treatment is the textbook definition of professional malpractice. Furthermore, the acceptance of the distinction within the medical profession grows mistrust and suspicion between the patient and the

doctor and leads to abuse, slippery slope and vulnerability of patients. Therefore, the distinction is practically, and normatively unjustifiable. From the point of development and progress in medical history the distinction is methodologically degressive. There is possibility that those patients who are suffering from deadly diseases will be killed and the efforts needed to help such cases will not be spent. Therefore, it removes the skeptic nature of scientific methodology which is progressive; as a result, the distinction becomes practically unjustifiable.

Rachels's third distinction, ordinary and extraordinary medical treatment, dissolves the distinction; the distinction is endorsed in AMA's statement and has proponents such as Thomas Sullivan. Rachels claims that the distinction is useless and senseless. He argues that there is no demarcation between ordinary and extraordinary and it is sometimes permissible to omit ordinary treatments. The research shows that the distinction as held in AMA's statement is valid and useful. The research shows that the distinction is evolutionary and progressive. Technologically, medicine has advanced so quickly that older understanding of the distinction seems obsolete. What might have been considered extraordinary care a few years ago is now so commonplace as to be called ordinary. As a matter of fact, the distinction between ordinary and extraordinary depends on the prudence, experience, and expertise of a physician; it is like the legal criterion of 'the reasonable man' and the criterion works in a rough and ready way at the practical level. Therefore, it is in essence a practical matter; therefore Rachels's claim on the issue is practically and conceptually unjustifiable. Rachels's additional claim is that instead of debating ordinary and extraordinary medical treatment, physicians should decide whether the life in question to be prolonged. The

claim is normatively unjustifiable because the benefit of the care to the patient's health condition is what is a real matter a doctor should be concerned about; deciding the life and death for the patient puts the physician in an unwarranted prerogative role which is problematic due to legal complexities, rights, duties, and autonomy. Such a judgmental role is also prone to abuse and corruption. The doctor's role is not to assess the value or worth of the patient but that of the treatment.

As noted earlier, Rachels argues against the traditional doctrine (TDE) or conventional doctrine on euthanasia (CDE) which is also called standard view, which according to Rachels makes a distinction between active, killing, and passive 'letting die' euthanasia and prohibits active and allows passive. This view, on Rachels's understanding, is upheld by the American Medical Association. Rachels's arguments are aimed against AMA's position exclusively. The research shows that Rachels's active-passive categorization of AMA's statement is a mistaken interpretation. The statement prohibits intentional killing of terminally ill patients and allows the cessation of extraordinary medical treatment. Rachels gives four arguments against AMA's position and which on his formulation render the distinction between active and passive euthanasia morally absurd. Therefore, his conclusion is that where passive euthanasia is allowed, active euthanasia should be permitted but preferred too. The research demonstrates the invalidity of Rachels's arguments, therefore the research leads to invalidity of the establishment of the validity of active euthanasia on the basis of the permissibility of so called passive euthanasia. Furthermore, the research shows that Rachels's claim of equating active and passive euthanasia morally is theoretically unjustifiable.

Rachels's first claim is that often active euthanasia seems more humane than passive and therefore active euthanasia should not be only permitted but preferred too. Rachels's reinforces his position in mercy argument. Rachels's position is based on the suffering of terminally ill patients and that on his view such suffering can be eliminated by active euthanasia. The research shows two main responses to Rachels's claim which render his argument invalid.

The first response is that Rachels argues against CDE on the basis not included in the AMA's statement. According the AMA's statement, CDE is not based on suffering and no consideration is included on methods which produce less or more suffering. Therefore, Rachels's argument against AMA's position is irrelevant. The second response is made if Rachels's argument is taken against CDE on the basis of suffering although not considered in AMA's statement. Even though, the research forwards the reasons which render Rachels's argument unimportant, irrelevant, and inadequate. There are two main reasons against Rachels's claim.

The first reason is that, allowing euthanasia would risk killing people who could otherwise have had years of more life. The case from the practical point goes against the active euthanasia, because recovery is a probability. Furthermore, the active euthanasia in the case leads to fallacy: appeal to future. Because the defender of active euthanasia takes the death of the patient granted. Therefore, Rachels's claim is practically and normatively indefensible. The second reason is that modern advanced medical technology has the most developed treatment to control the pain or suffering of terminally ill patients. From the practical point of view suffering is irrelevant to the

issue of euthanasia due to advances in palliative care and pain medication. Therefore active euthanasia seems undesirable. The other important notion which is connected with suffering is the conception of the nature of suffering itself. The suffering can be physical and it can be also mental or psychological. If suffering becomes the basis for the permissibility of active euthanasia, then many patients who are not terminally ill but psychologically suffering or non-terminally ill, will be subjects of euthanasia as well. Therefore, suffering as itself is an inadequate reason for permissibility of active euthanasia. Furthermore, suffering is actually about the attitude; it extends into metaphysical questions about the nature of human happiness and of what constitutes a meaningful life. On the whole, Rachles's position is conceptually and practically indefensible.

However, while it may be true any terminally ill patient might, for very good reasons, no longer wish to prolong his or her life. These cases are cited in Rachels's works also. However, the reason which renders such a position invalid is that the cases are of patients who are being kept alive by extraordinary means; their death is being prolonged due to inappropriate use of advanced medical technology. The point is that if a person could not be cured by ordinary treatment, providing extraordinary treatment to such a patient when death is foreseen would only create suffering. Unfortunately, Rachels has missed this point in his works. However, Rachels argues that there are still patients, their death is foreseen and instead of killing them they are left to die and their dying process takes days and weeks in suffering. He therefore argues that such patients could have been better off by active euthanasia by putting end to their suffering. The research argues against it by two reasons. The first is that pain medication and

palliative care has made suffering irrelevant. The second reason is that those patients who are terminally ill and their life may be miserable due to the pain which is caused by illness, for such patients, double doctrine effect (DDE) opens the way and avoids any need of active euthanasia. On the whole, Rachels's claim of killing a patient is practically unjustifiable because in light of above reasons there appears no need of killing a terminally ill patient.

Rachels's second claim is that the conventional view makes life-and-death decisions on irrelevant grounds therefore the conventional view, CDE, is not true. Rachels claims that those irrelevant grounds are 'killing' and 'letting die'; and according to him the relevant ground should be elimination of suffering. The research shows that the relevant grounds in CDE are the killing and termination of extraordinary medical care. The elimination of suffering is not included; its irrelevance is shown in the preceding arguments. Rachels's claim against CDE is theoretically unjustifiable. Furthermore, irrelevance of 'killing' and 'letting die' is already shown earlier in the criticism of the conceptual framework, and its irrelevance is further shown in the criticism of the following claim .

Rachels's third claim is that there is no moral difference between doings and refraining, therefore wherever refraining is allowed doing should be permitted too; in other words, wherever passive euthanasia is allowed active should be allowed too. Rachels attempts to demonstrate that active and passive distinction is without any difference. The research shows that Rachels's argument is invalid due to four reasons: (1) irrelevance to AMA's statement; (2) differences between the cases because of

intentionality, causality, and agency; (3) straw man fallacy, (4) and weak analogy.

The first reason is that the argument is irrelevant to AMA's statement which does not make any distinction between killing and letting die, therefore Rachels's argument against the statement is irrelevant. The second reason is that in active euthanasia killing is intended whereas death in passive euthanasia happens naturally without any intention. Furthermore, closely connected is the legal distinction between ignorance of law and ignorance of fact. In legal judgments of the actions intentions are considered; a crime committed intentionally receives greater punishment than the same act done unintentionally. Moreover, causation and agency also makes the cases different: in active euthanasia the cause is lethal injection and the agency is a physician, whereas in passive euthanasia the cause and agency are the underlying disease. The third reason is that Rachels makes very superficial and shallow claim that if a patient is dying and could be in fact cured and doctor leaves such a patient without care and such a patient dies and in the case killing and letting die would make no difference. This reason is very irresponsible and subject to fallacies such as straw man fallacy, missing the point, and equivocation; because terminating ordinary medical care when the patient is potentially able to recover is not the subject matter of active euthanasia or passive euthanasia. The fourth reason is that Rachels's illustration of Smith and Johns in support of his argument commits fallacy of weak analogy, the cases are not analogous. Because, the distinction between active and passive euthanasia lies in the patient's autonomy and ability to refuse treatment. Due the above reasons, Rachels's claim becomes theoretically unjustifiable, because active and passive are distinctly different.

Rachels's fourth claim is that often heard argument for the conventional view, which states is that in passive euthanasia doctor does nothing whereas in active doctor is the cause of death, is unsound. Because, the doctor does something, he lets the patient die. Rachels repeats his straw man fallacy as in preceding claim; the research shows that it is the underlying disease which causes the death, not the doctor. Therefore, Rachels's claim becomes theoretically unjustifiable.

The research, after criticizing the conceptual framework, and Rachels's arguments against CDE, criticizes Rachels's direct arguments for active euthanasia. The research shows that Rachels's arguments for active euthanasia are three types: (1) argument based on biological and biographical distinction, (2) arguments based on CDE by dissolving the distinction between active euthanasia and passive euthanasia; these two types can be classified as indirect arguments; and (3) direct arguments for active euthanasia. These direct arguments are: (1) argument from mercy, (2) argument from the best interests and golden rule, and (3) argument from autonomy. And finally, he proposes a 'modest proposal' on the legalization of active euthanasia. The research shows that Rachels's argument for active euthanasia are interconnected in a way that no argument stands on its own to support his position. His first argument from mercy shows the problem of pure utilitarianism, to remove such a difficulty, he moves to best interest argument, where he feels helpless and turns to the golden rule argument and the golden rule argument ultimately depends on autonomy. Autonomy becomes problematic and more problematic by his legislation proposal on active euthanasia.

Rachels's first argument from mercy is not different from his first argument against CDE. Rachels's position is that it is cruel and inhumane to refuse the plea of a terminally ill person that his or her life be ended to avoid unnecessary suffering and pain. Allowing such a person to terminate his or her life is an act of mercy. As noted earlier, the research demonstrates the reasons which render Rachels's argument unimportant, irrelevant, and inadequate.

Rachels's second argument is from the best interests and golden rule. In short, the argument holds that if active euthanasia promotes the best interest of everyone concerned, and violates no one's rights, then it should be is morally acceptable. He further uses Kantian categorical imperative that if we like euthanasia applied to us, we should like it to be applied to others.

The research demonstrates three reasons which render the argument invalid. They are: (1) the argument is based on subjective moral judgment, failing the universalization test; (2) it may not be in my own best interests or in the best interests of others for me to die; and (3) the argument is based on indefensible autonomy.

The research demonstrates that the best interest and golden rule arguments are based on subjective moral judgment, therefore the arguments fail the morally universalization test and become subject of partiality. The relevance of universalization test is due to Rachels's acceptance of categorical imperative. In short, if a person takes anything in his own interest, it does not guarantee that such an act would be desirable to other people. Similarly, not everything people would wish to have done to them is morally appropriate. Some terminally ill patients may like to be

killed, but their wishes are not enough to establish a moral rule, because they are pointing to their own pain as a justification for carving out an exception to the general legal and moral rule against intentionally killing the innocent. Furthermore, the research by referring to various studies establishes the fact that even approval of some terminally ill patients for active euthanasia is due to treatable depression; and because of other factors the approval of such patients turn out to be a matter of completion instead of free autonomous wish. Moreover as the research mentioned earlier the relation of categorical imperative, Rachels's understanding of Kant turns out to be a misinterpretation. Because, Kant argued that taking one's own life was inconsistent with the notion of autonomy, properly understood. Autonomy, in Kant's view, does not mean the freedom to do whatever one wants, but instead depends on the knowing subjugation of one's desires and inclinations to one's rational understanding of universally valid moral rules. According to Kant, our rational wills are the source of our moral duty, and it is therefore a kind of practical contradiction to suppose that the same will can permissibly destroy itself. Given the distinctive worth of an autonomous rational will, suicide is an attack on the very source of moral authority. Therefore, due to these reasons, Rachels's claim of killing a terminally ill patient on the basis of the best interest and golden rule becomes normatively and theoretically unjustifiable.

Rachels's third argument is from autonomy. Rachels's conception of biographical life entails that a human being is autonomous; therefore, if a person autonomously chooses to end his or her life then it is morally permissible. Rachels also supports his position by the of analogy to the law of suicide; since it is not unlawful for a person to commit or attempt to commit suicide, therefore such a person should be

able to seek the assistance of others in achieving this end. Importantly, the argument from autonomy stands as the foundation of Rachels's thesis which according to him is based on the golden rule and the best interest argument.

The research demonstrates that argument from autonomy fails to claim the sufficient support to substantiate a pro-position for the approval of active euthanasia. The related reasons are: (1) invalidity of civil right's claim; (2) weak analogy between suicide and euthanasia; (3) unwarranted influence of patient's autonomy on doctor's autonomy; and (4) unattainable autonomy of the terminally ill patients.

The first reason is that civil rights claim from right of property and right to death is invalid. Because, our selves are not sufficiently distinct from our bodies to make ownership of the body; and it does not seem to follow from having a right to life that a person has a right to death. The second reason is that Rachels's commits fallacy of weak analogy between suicide and euthanasia. Because, suicide is a civil liberty, whereas euthanasia is a civil right, there exists the important distinction between them because suicide is an autonomous and self-regarding act, and active voluntary euthanasia requires the involvement and assistance of a second party. Furthermore, if the argument for active voluntary euthanasia is based on dignity of human freedom and self-determination, then it is inconsistent to ask someone else to assist. The third reason is that by accepting patient's autonomy it will have unwarranted influence on doctor's autonomy. The creation of any right to active euthanasia tends to imply a corresponding duty on the part of someone to become actively involved in bringing about death. Because of the adverse consequence, in the US constitutional context, the

courts have already indicated that the recognition of a constitutional right to physician assisted suicide does not entail any duty on the part of any doctor. There is broad agreement amongst euthanasia advocates that it would be inappropriate to impose a duty on any person to take the life of another. Although such a duty would uphold the autonomy of the patient who requests assistance, it is recognized that it would be an unjustifiable interference with the autonomy of others. It is primarily to avoid the implication of any such duty and the resulting infringement of the autonomy of other parties that a strictly rights-based model has been widely rejected as an appropriate basis for the legalization of active voluntary euthanasia. The fourth reason is that autonomy of the patients is practically unattainable. Because, disease and pain medication can cause clouding of patient's mind, outside forces can influence the patient's will, furthermore the research shows that the patients who desire an early death during a serious terminal illness are usually suffering from a treatable depressive condition. In light of all these reasons, Rachels's claim from autonomy becomes normatively, practically, and conceptually unjustifiable.

Rachels proposes "modest proposal" on the legalization of active euthanasia. According to his proposal a physician who kills a patient would be acquitted on proving that the patient requested so and by pleading mercy killing. Rachels claims that under the proposal no one would be authorized to decide when a patient should be killed. Rachels further explains that by following the proposal we would rely on the good sense of judges and juries to separate the cases of justifiable euthanasia from the cases of unjustifiable murder, just as we already rely on them to separate the cases of self-defense and insanity and coercion. The research demonstrates that Rachels's

proposal on legalizing active euthanasia is problematic and after analyzing his proposal from the legal and practical points, his proposal turns out to be impractical. The research shows that the proposal fails to provide clear guidelines. The proposal suggests that after mercy killing a criminal trial can acquit the physician, the impossibility arises when the murdered person is killed and there is no one left to follow his killing or those who follow have vested interests. The research shows that Rachels is very naive about homicide and criminal law procedures. He suggest that there will be no one to follow the murder case as guardians will give consent positively, and therefore he ignores the role of the state and police . Rachels confuses criminal trial with civil trial. The further complication arises that not many physicians would be ready to face trials after mercy killing in absence of any guidelines and legalized procedures. The biggest problem which the proposal fails to deal with is that on one hand Rachels dismisses any committees which could decide the euthanasia, whereas on the other hand he leaves the matter unto doctors that they could defend themselves on commonsense or ignorance of fact, which gives an easy hand to a doctor to kill people without any requirements. On the whole, Rachels's proposal is practically unjustifiable.

On the whole, the researcher has demonstrated throughout of this study that Rachels's conceptual framework , his arguments against CDE , his arguments for active euthanasia, and his proposal on the legalization of active euthanasia, are normatively, practically, theoretically, and conceptually unjustifiable.

Equally important, are the findings of this research regarding the scrutiny into the nature of euthanasia, its definition, origin, and solution. The research agrees only with the narrow construal definition of euthanasia: only active euthanasia. And suggests its prohibition. To support such a position, the research develops three propositions: (1) prolonging of death is one of the moral hazards of advanced medical technology; (2) the cases of passive euthanasia are the cases of the natural state of extinction; and (3) the need of active euthanasia as defended by Rachels due to some case studies of patients is un-justifiable due to two reasons: (1) that the cases are actually mishandled by the misuse of advanced medical technology and (2) if there are terminally ill patients in anticipation of death and living in painful state such patients could be dealt by the use of doctrine of double effect (DDE). The research demonstrates that AMA's statement on euthanasia is valid. In addition, the patients should not be intentionally killed and extraordinary medical treatment can be withdrawn or withheld by the permission of the patient or due to hopeless condition of the patient by the permission of his legal guardians. Furthermore, Rachels's categorization of active and passive euthanasia into killing and letting die is a false dichotomy: Rachels gives two choices; either killing or letting die, and prefers killing to letting die. Whereas the research demonstrates that both of these choices killing and letting die are irrelevant. The third and only choice is to stop prolongation of death by medical technology, to allow termination of extraordinary medical care from dying person by following legitimate procedures, and to allow use of pain medication.

Further Research and Recommendations

The researcher would like to suggest and recommend that there is need of further research in the field of palliative care to make it more efficient and comforting. The further research is also needed in the area of denaturalized advanced medical services and facilities; these services and facilities are in need of ethical evaluation which can help in setting the proper procedures for their use. Moreover, dehumanizing nature of advanced medical technology deserves a multidisciplinary scrutiny. There is also an urgent need of research in the field of cross-cultural family values. The researcher believes that there are many family values which could be learnt from the Eastern cultures in looking after the elderly and terminally ill family members.

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Autobiography

I was born in Kashmir, India in the year 1971. After completing the higher secondary education in Kashmir, I moved to Lucknow where I lived from 1992 until 1998. Over the years of stay in Lucknow, I received B.A. and LL.B. from the Lucknow University; and B.Th. and M.Th. from Darul Uloom Nadwat-Ul-Ulama. In 1999, I moved to Bangkok and received an M.A. in philosophy from the Assumption University in the year 2002. Since 1999, while being the postgraduate student at the Assumption University, I worked for many community run and private educational institutions in the areas of teaching and management. Alongside, I have been working as an interpreter and translator; and have taught courses on politics and business at the University of the Thai Chamber of Commerce. I am currently a freelance translator and interpreter and consultant to International Rescue Committee (IRC). I can be reached at: philomalik@gmail.com.